Supreme Court, U.S.
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No. OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

GEORGE O. KRIZEK, M.D.
AND
BLANKA H. KRIZEK,

Petitioners,

v.

UNITED STATES,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether alleged injury to the Government's sovereignty, without proof of actual financial damages to the Government, suffices to establish standing to sue under the False Claims Act, in light of this court's decision in *Vermont Agency of Natural Resources v. Stevens*, 529 U.S. 765 (2000).

2. Whether allegedly incorrect use of Current Procedural Terminology ("CPT") codes, which are privately copyrighted, not promulgated as a rule under the Administrative Procedure Act, and utilized by the Government pursuant to a contract, constitutes injury to sovereignty as contemplated by this court in the *Stevens* decision.

3. Whether the congressional schemes of the Social Security Act and related Medicare and Medicaid legislation, and the False Claims Act preclude a claim for restitution on the ground of unjust enrichment under this court's ruling in *Buckman County v. Plaintiffs' Legal Committee*, 121 S. Ct. 1012 (2001).

PARTIES TO THE PROCEEDINGS BELOW

Petitioners, George O. Krizek, M.D. and Blanka H. Krizek, were appellants in the proceedings below. Respondent, the United States, suing through the United States Attorney's Office for the District of Columbia, was appellee in the proceedings below.

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PETITION FOR WRIT OF CERTIORARI

Petitioners George O. Krizek, M.D. and Blanka H. Krizek respectfully petition for a writ of certiorari to review the affirmance by the Court of Appeals for the District of Columbia Circuit of the decision of the United States District Court for the District of Columbia in a False Claims Act case.

OPINIONS BELOW

The Order of the Court of Appeals denying petitioners' request for a rehearing and rehearing en banc (App. 69a) was entered on July 19, 2001 and is unreported. The Order of the Court of Appeals granting summary affirmance for the Government (App. 1a) was entered on April 17, 2001 and is reported at 2001 U.S. App. LEXIS 10939. The Order of Judgment of the District Court (App. 71a) was entered on August 29, 2000 and is unreported. The published opinions are set forth as follows, in reverse chronological order:
United States v. Krizek, App. 4a-17a;
United States v. Krizek, App. 18a-27a;
United States v. Krizek, App.28a-45a;
United States v. Krizek, App. 46a-50a;
United States v. Krizek, App. 51a-68a.

JURISDICTION

The Court of Appeals denied the request of the petitioners for a panel rehearing and a rehearing en banc on July 17, 2001. The petition for a writ of certiorari is accordingly due no later than October 17, 2001. The jurisdiction of this court is invoked under 28 U.S.C. 1257.

PERTINENT STATUTES

The text of the False Claims Act, 31 U.S.C. 3729-3732, is set forth at App. 72a-83a. The partial text of the Social

Security Act, 42 U.S.C. 1395 is set forth at App. 84a. Relevant regulations of the Health Care Financing Administration, 42 C.F.R. 405.305 *et seq.* and 42 C.F.R. 424.32, are set forth, respectively, at App. 85a-86a and App. 87a-88a.

STATEMENT OF THE CASE

This case concerns a dedicated doctor and the extraordinary, unprecedented steps that the Federal Government took to shut down his medical practice and to destroy his professional reputation and livelihood.

Dr. George Krizek is a skilled, Board-certified psychiatrist who served thousands of old and poor patients "afflicted with horribly severe psychiatric disorders," *United States v. Krizek*, App. 54a. For twenty-one years, Dr. Krizek treated patients at Washington Hospital Center, an 800-bed inner city hospital in the Nation's Capital. Trial Tr. (3/30/94) at 96-100 and (4/5/94) at 65. Dr. Krizek worked "long hours on behalf of his patients" seven days a week and often covered for his colleagues on weekends and vacations. App. 54a; Trial Tr. (4/5/94) at 64-65. Without warning, the Government accused him of fraud, sued him and forced him to close his small practice. Trial Tr. (4/5/94) at 42-43.

A. The Government's Case

The Government sued Dr. Krizek and his wife, who performed some of his billing, for fraud under the civil False Claims Act, 31 U.S.C. 3729 *et seq.*, and for unjust enrichment, among other theories. *United States v. Krizek*, App. 51a-52a. The Government took no direct issue with the quality of Dr. Krizek's medical skills. Instead, the Government accused Dr. Krizek of providing "medically unnecessary" services. App. 52a. The Government also accused the doctor of choosing the wrong "Current Procedural Terminology" ("CPT") codes, a set of numerical identifiers corresponding to various common medical procedures (which is copyrighted by the American Medical

Association ("AMA")) to bill Medicare and Medicaid for the medical treatment that he provided to his patients. *Id.*

The Government went to great lengths to attempt to discredit Dr. Krizek's medical decision-making. The Government argued that "some patients should have been discharged from the hospital sooner, and that others suffered from conditions which could not be ameliorated through psychotherapy sessions, or that the length of the psychotherapy sessions should have been abbreviated." App. 55a. The Government's attack on the billing codes that Dr. Krizek chose to describe his inpatient psychiatric services was even more heavy-handed, the Government claiming that at least 57% of medical care provided by Dr. Krizek was misbilled. App. 55a-56a.

B. The District Court Findings

After a three-week bench trial in 1994, the United States District Court for the District of Columbia ("District Court") found that Dr. Krizek had never rendered "medically unnecessary" services. App. 55a. The District Court also found that the Government's interpretation of the meaning of varous CPT codes was "not rational and has been applied in an unfair manner to the medical community." App. 59a. The District Court found "unseemly" the Government's effort to present Dr. Krizek as "public enemy number one." App. 60a. at n.3.

Notwithstanding these findings in favor of Dr. Krizek, the District Court faulted Dr. and Mrs. Krizek for having a "deficient" billing system, finding that Dr. Krizek failed to exercise adequate supervision over the selection of the CPT codes submitted on his behalf, and to ensure that his wife or other billing agent made sufficient efforts to determine the time that Dr. Krizek spent providing each service, a requirement that the District Court read into the CPT codes. App. 61a-62a. As a consequence of these two findings, and despite "unrefuted testimony that Dr. Krizek worked very long hours,", App. 63a, the District Court decided that bills were submitted on Dr. Krizek's behalf when he "could not have spent" the "requisite"

amount of time providing medical services. *Id.* Thus, the District Court determined that under the language of the FCA, it was "compelled to conclude that the [petitioners] acted with reckless disregard as to the truth or falsity of the submissions" and "deemed" them to have violated the FCA, without finding that the Government suffered any damage as a result of said violation. App. 66a. Seven years of litigation have followed.

C. Dr. Krizek's Background

Dr. Krizek was born in Prague in then-Czechoslovakia and graduated *summa cum laude* from Charles University, Central Europe's oldest medical school, founded in 1348. Trial Tr. (3/30/94) at 96-100. Dr. Krizek taught psychiatry and neurology as an assistant professor, and then became Head of the Charles University Outpatient Psychiatric Clinic. Pressured to join the Communist party and to conduct politically-motivated psychiatric evaluations, Dr. Krizek defected to Austria in 1966, thereafter receiving a second medical degree from the University of Vienna. *Id.*

In 1968, Dr. Krizek emigrated to the United States with his family and was admitted into a medical residency program, specializing in the treatment of substance abuse disorders, at Beth Israel, a teaching hospital in New York City. *Id.* at 96-100. In the early 1970s, Dr. Krizek settled in Washington, D.C. and began to treat Medicare and Medicaid patients, while his wife performed some of the billing. *Id.* Dr. Krizek earned a comfortable living but was by no means enriched by his psychiatric practice, earning about $100,000 a year at the time that the Government's lawsuit was brought. *Id.* at 11

D. The Government's Investigation

On December 12, 1989, Mrs. Krizek received a telephone call asking if she would be at home "to receive a Christmas delivery." Trial Tr. (4/7/94) at 22-24. A short while later, Mrs. Krizek answered her front door to find "three large people," two men and a woman, who flashed badges at her and pushed their way inside, insisting that they had "some questions regarding Dr. Krizek's billing to Medicaid." Trial Tr. (3/28/94) at 89; Dep. Tr., Dep. of Blanka Krizek (3/16/94) at 17-35. The intruders were Special Agents from the Office of Inspector General of the Department of Health and Human Services ("OIG"), and included two former FBI agents in undercover counter-intelligence surveillance, who had been reassigned to health care investigations. Trial Tr. (3/28/94) at 85-86, 117. The agents had no subpoena. Trial Tr. (3/24/94) at 104.

For the next several hours, the OIG agents yelled at and ridiculed Mrs. Krizek (and later Dr. Krizek), making fun of her foreign accent, and accusing her of double-billing, billing for nonexistent patients, and "enriching herself," and told her that she and her "hubby" were committing fraud. In short, the OIG agents "tried to scare [her] to death." Trial Tr. (4/7/94) at 48, 57, 62-63; (3/28/94 at 94, 113; Dep. Tr. at 17-35.

The OIG agents had a list of names of Dr. Krizek's patients that they claimed did not exist. Trial Tr. (3/24/94) at 112. Mrs. Krizek, terrified and "shaking," was able to produce a file for each patient. Dep. Tr. (3/16/94) at 17-35. After making more outrageous accusations that Mrs. Krizek denied, the agents, laughing among themselves and having a "great time," left. Trial Tr. 3/28/94 at 113; Dep. Tr. at 17-35. For Mrs. Krizek, it was "the most unpleasant experience in [her] quarter of a century [in America]." Dep. Tr. at 20.

In this way, the twelve-year ordeal of petitioners began. The OIG agents spent several days rummaging through psychiatric patient files at Washington Hospital Center, without a subpoena, in an effort to find evidence of fraud. Trial Tr.

(3/24/94) at 97; (3/28/94) at 109-110. They next contacted numerous doctors and nurses who worked with Dr. Krizek, and several of Dr. Krizek's patients, and questioned them regarding Dr. Krizek's "fraudulent" billing and "medically unnecessary" services. Trial Tr. (3/24/94) at 132, 135-136.

Despite these coercive practices, the OIG agents were not able to find a single doctor, nurse or patient to testify for the Government that Dr. Krizek had done anything wrong. Trial Tr. (3/28/94) at 49-50. Several doctors and a head nurse, however, testified on Dr. Krizek's behalf at trial. Trial Tr. (3/29/94) at 122-174 and (3/30/94) at 3-92. One of Dr. Krizek's patients, a man with a severe disability who had been treated by the doctor for twenty years, was so outraged by the Government's tactics and accusations that he volunteered to be a defense witness. Trial Tr. (4/7/94) at 73-81.

In December, 1992, the petitioners received a Demand Letter from the United States Attorney's Office for the District of Columbia, inviting them to settle in a six-figure range for "fraudulent billing" or face a lawsuit. *See* Testimony Before the Subcommittee on Commercial and Administrative Law, House Committee on the Judiciary, "Administrative Crimes and Quasi Crimes," May 7, 1998 ("House Testimony"), App. 89a-98a. When they refused, this lawsuit was filed in January, 1993, and publicized by the local Washington media. Trial Tr. (4/7/94) at 80-81; Department of Justice Press Release, 1/11/93.

E. The Government's "Evidence"

The District Court never required the Government to prove the falsity of any specific claims for payment submitted by Dr. Krizek. *United States v. Krizek*, App. 31a-32a, 39a. Instead, it developed a series of proxies for proof. First, the District Court permitted a "defective" billing system to stand in for fraud liability. *United States v. Krizek*, App. 31a . Then, on the basis of the trial testimony of one defense witness concerning his own personal work habits, the District Court concluded that nine hours was the appropriate average length of a doctor's workday,

and that any claims submitted by Dr. Krizek for services rendered beyond a nine-hour workday should be "presumed improper." *United States v. Krizek*, App. 48a. Pursuant to its presumption of a nine-hour workday, the District Court retained a Special Master, with costs to be split between the parties, to ascertain how many false and improper claims the petitioners had submitted, and how much they had been paid for these claims. App. 47a-48a. The Special Master then spent time counting treatment minutes in Government-supplied and Government-summarized printouts, conducting research on what constitutes a "claim," and making findings of fact concerning the hours that Dr. Krizek allegedly claimed to have worked above the nine-hour daily maximum. *Id.; United States v. Krizek*, App. 44a-45a.

In order to fulfill his task, the Special Master adopted Government interpretations of the legal significance and minimum time requirements of several specific CPT codes, and determined that a CPT code constitutes a claim for payment. App. 37a. Eventually, using the court's definitions and his own legal conclusions about the meaning and role of the CPT codes, the Special Master found that Dr. Krizek had submitted 1,149 claims for over nine hours of work on 264 days in six years, and thus owed the Government $5,745,000 in trebled damages and penalties under the FCA. App. 32a. [1]

F. The District Court's Initial Response

After receiving the Special Master's results, the District Court changed its mind, and determined that most of Dr. Krizek's claims were not false after all, merely improper. *United States v. Krizek*, App. 48a. The District Court ordered petitioners to refund the Government the total sum of $47,105.39 that Dr.

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[1] Arriving at these figures was no easy task – in fact, the Special Master was forced to concoct a unique and untested alchemical CPT code counting, ordering and prioritizing "methodology" in order to mold raw data to meet the court's requirements. *Id.* App. 15a, 20a. The Special Master then charged the parties $22,000 for his special work. *Id.*

Krizek had been paid for the "improper" 1,149 claims allegedly made in excess of a nine-hour workday over six years. *Id.* Then, the court determined that on three days, 11 claims had been submitted exceeding a twenty-four hour day (using the Government's time calculations), and that these 11 claims were, in fact, false under the FCA. App.48a. The court appeared to mix apples and oranges by declaring that the "[FCA] requires that [petitioners] be held liable for triple the amount unjustly paid to them and fined between $5,000 and $10,000 for each claim covered by the FCA." *Id.* Without further explanation, however, the court fined the petitioners $110,000 for 11 alleged violations of the FCA, with no damages. App. 49a. The petitioners were held liable for a total of $157, 105.39 in 1995. *Id.* As part of the judgment, the District Court also enjoined the petitioners from billing to Medicare and Medicaid "until such time as thet can show the Court that they can abide by the relevant rules." *United States v. Krizek*, App. 67a.

G. The Appeals and Remands

Appeals followed on both sides. On remand in 1998, the District Court lowered petitioners' total liability to $77,105.39. *United States v. Krizek*, App. 27a. On yet another remand, the District Court, with a new trial judge assigned to the case, increased the petitioners' liability to $237,105.39.[2] *See* Order of

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[2] Initially, after this lawsuit was filed, Dr. and Mrs. Krizek were optimistic that the truth and common sense would prevail. By the time of their trial in the District Court in March, 1994, however, the petitioners grew increasingly disheartened and bewildered. Before and during the three-week trial, Dr. Krizek was unable to return to Prague to spend time with his hospitalized 87-year-old-mother, the widow of a Resistance fighter, before she died. *See* House Testimony , App. 96a-97a.. During the trial, Dr. Krizek could no longer concentrate on his medical practice and withdrew from treating patients:

> I am anxious, depressed, and have the feeling I am fighting for my life now, and for the life of my relatives, and family and reputation. Trial Tr. (4/5/94) at 42-43.

Dr. Krizek has not practiced since, and has subsequently developed cancer.

Judgment, August 29, 2000, App. 71a.

In October, 2000, the petitioners appealed the District Court's most recent judgment against them of $237,105.39. The petitioners raised several issues on appeal. First, the petitioners challenged the jurisdiction of the District Court over the Government's lawsuit under the FCA, because the Government failed to prove actual damages caused by any alleged FCA violation of the petitioners. Secondly, the petitioners averred that if actual financial loss is not an essential element of a civil FCA case, then the statute is criminal in nature and the petitioners were denied their due process rights. Thirdly, the petitioners challenged the District Court's penalty under the FCA as an excessive fine under the Eighth Amendment, and lastly, the petitioners challenged the District Court's jurisdiction to hear the Government's unjust enrichment claim.

At the Government's urging, the Court of Appeals summarily affirmed the District Court's judgment judgment without giving the petitioners an opportunity to brief the court on the important jurisdictional issues involved. *United States v. Krizek,* App. 2a. The Court of Appeals disposed of the petitioners' excessive fines, due process and unjust enrichment challenges on waiver grounds. *Id.* With respect to the petitioners' challenge to the District Court's jurisdiction over the Government's FCA claim, the Court of Appeals simply stated: "[The Government] has standing to bring this case," citing *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, [529 U.S. 765, 771], 120 S. Ct 1858, 1862 (2000). *Id.* The Court of Appeals then denied, without comment, the petitioners' request for a rehearing of its summary affirmance, thereby prompting this petition. *United States v. Krizek,* App. 69a-70a.

The Government has "won" in this case through legal criteria created *ex post facto* and applied retroactively. The attempts of the petitioners to discover why they became the specific targets of an OIG fraud investigation, pursuant to the Freedom of Information Act, have been unsuccessful. Dr. Krizek has been judicially punished for some sort of alleged billing

transgression, even in the absence of proven damages. Yet, the petitioners have never had a fundamental question answered to their satisfaction: what exact legal standard have they breached?

SUMMARY OF ARGUMENT

1. The District Court's imposition of a civil penalty, without any proof of actual damages caused by the petitioners' alleged violation of the FCA, does not square with this court's decision in *Vermont Agency of Natural Resources v. Stevens*, 529 U.S. 765 (2000). Moreover, the lower federal courts are divided over the kind of evidence necessary to prove damages sufficient for the Government to sustain a civil action under the FCA. Because of the absence of economic injury to the Government, the District Court simply did not possess the jurisdiction to impose civil penalties against Dr. and Mrs. Krizek under the FCA.

2. The District Court's award of $47,105.39 to the Government, under the separate theory of unjust enrichment, squarely conflicts with another recent decision of this court in *Buckman Company v. Plaintiffs' Legal Committee*, 121 S. Ct. 1012 (2001). Just as the statute discussed in that case, the False Claims Act and the Social Security Act, together with related Medicare and Medicaid legislation, are comprehensive remedial schemes created by Congress which preclude common law remedies. The District Court did not have the jurisdiction to reach outside of those remedial schemes to make a separate award of damages to the Government.

ARGUMENTS FOR GRANTING THE WRIT

I. THE COURTS OF APPEALS ARE DIVIDED ON THE ISSUE OF WHETHER THE GOVERNMENT MUST PROVE INJURY TO THE PUBLIC FISC IN ORDER TO HAVE STANDING TO SUE UNDER THE FALSE CLAIMS ACT

This court stated in *Vermont Agency of Natural*

Resources v. United States ex rel. Stevens that standing to sue under the False Claims Act ("FCA") was predicated in that case on two types of possible injury to the Government resulting from a false claim: "both the injury to its sovereignty arising from violation of its laws (which suffices to support a criminal lawsuit by the Government) and the proprietary injury resulting from the alleged fraud." 529 U.S. 765, 771 (2000). The implication of this decision is that standing to sue under the FCA exists if the Government suffers *both* sovereign and economic injury, or if it suffers economic injury alone. However, *sovereign* injury alone does not confer standing under the FCA, because it is a civil, and not criminal, statute. [3]

The FCA characterizes "damages" as an "essential element of the cause of action" under the statute. *See* 31 U.S.C. Sec. 3731 (c), App. 82a. Federal courts differ, however, on whether proof of damages to the Federal fisc is required, or whether proof of other types of damages *alone* suffices to establish standing to sue under the statute. *Compare, e.g. Varljen v. Cleveland Gear Co.*, 250 F.3d 426, 429 (6th Cir. 2001)(recovery under the FCA is not dependent upon the government's sustaining monetary damages); *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 785, note 7 (4th Cir. 1999)(there is no requirement under the FCA that the government have suffered damages as a result of the fraud); *Bly-Magee v. California*, 236 F.3d 1014, 1017 (9th Cir. 2001)(a Qui Tam plaintiff need not prove that federal government will suffer monetary harm to state a claim under the FCA) *with Hutchins v. Wilentz*, 253 F.3d 176, 184(3rd Cir. 2001)(the FCA only prohibits fraudulent claims that cause economic loss, or potential economic loss, to the government); *Manning v. Utilities Mutual Life Insurance Co.*, 254 F.3d 387, 394(2d Cir. 2001)(the FCA allows individual citizens, as well as the government, to sue in order to right an economic wrong done to the government).

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[3] This court has long compared the Government's role as contractor and as sovereign. *See, e.g. Horowitz v. United States*, 267 U.S. 458, 461 (1925).

The Solicitor General has argued that no proof of economic damages is required under the FCA, but nevertheless concedes that the FCA requires that the Government have suffered an injury. *See* Brief for the United States as Amicus Curiae Supporting Respondent at 23-29, *Hughes Aircraft Co. v. United States ex rel. Schumer*, 117 S. Ct. 1871 (1997)(No. 95-1340). In its amicus brief in the *Hughes Aircraft* case before this court, the Government articulated a concept of injury that has been quietly present in many FCA judicial decisions. Under this view, "statutory and regulatory provisions regarding the government's acquisition of goods and services frequently establish criteria that are designed to serve *ancillary social policies*, rather than simply to ensure the quality of the goods and services obtained." *Hughes* Government Amicus Brief at 25-26. (emphasis supplied.)

Courts do engage in this type of policy analysis under the False Claims Act. For example, in *Rex Trailer Co. v. United States*, 350 U.S. 148, 152-153 & n. 5 (1956), explaining the earlier decision *United States ex rel. Marcus v. Hess*, 317 U.S. 537 (1943), the court found no harm to the Federal fisc, but rather injury to the policy of "affording veterans an opportunity to purchase [surplus] goods not available elsewhere at a fair price and on good credit terms" where the defendant misrepresented himself as a veteran. A later case, reflecting changing times and changing policies, again found no economic loss, but injury to the Government's program of assisting minority-owned businesses to be competitive in the marketplace, where the defendant misrepresented himself as a minority. *See Ab-Tech Construction, Inc. v. United States* 31 Fed. Cl. 429, 432 (1994), *aff'd* 57 F.3d 1084 (Fed. Cir. 1995).

The type of "policy injury" advanced by the Government, without more, comes squarely into conflict with this court's standing jurisprudence, which requires a plaintiff to prove "concrete" and "actual or imminent, not conjectural or hypothetical" injury. *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990). In order to resolve this conflict, some courts have imposed a materiality requirement on alleged false claims. *See.*

e.g. Harrison v. Westinghouse Savannah River Co., 176 F.3rd 776 at 778 (the FCA contains a "heightened materiality requirement: the Government must have conditioned payment of the claim...upon compliance with the provision of the statute, regulation or contract at issue"). As discussed below in Section II(B), the Solicitor General appears to agree that the civil FCA requires that false claims be material, "bearing on the claimant's *entitlement to payment.*" *Hughes* Government Amicus Brief at 25.

The *Stevens* holding, however, requires a more fundamental shift from federal courts. Before *Stevens*, courts assumed that it was correct to impose civil penalties as a type of 'liquidated damages" representing a rough form of compensation, on the assumption that the statute was primarily remedial, although *potentially* punitive. *See, e.g. United States v. Halper*, 490 U.S. 435, 442, 446, (1989). Now that the *Stevens* decision has clarified that the FCA *is* punitive, the Government must be required to prove specific damages under the statute to save it from being "quasi-criminal" under this court's decision in *Hudson v. United States*, 118 S. Ct. 488, 493 (1997).

The "current version of the FCA imposes damages that are essentially punitive in nature," *Stevens*, 529 U.S. 765, 784, because the FCA is a changeling -- a statute that started out life as a criminal statute (formerly known as the "Informer's Act"), and then became a civil statute. 529 U.S. 765 at 782. The original criminal False Claims Act, which imposes criminal penalties that include imprisonment, still exists and is codified at 18 U.S.C. 287. *Id.* at n. 11. Because the Government is free to sue under the criminal statute for injury to sovereignty alone, the bifurcation of false claims into civil and criminal makes no sense unless the Government bears a different standard of proof under the civil FCA.

Only a clear statement by this court that the Government must prove economic damages in order to have standing to sue under the FCA will resolve the analytical difficulties that lower courts are having with the current version of the civil FCA.

II. ALLEGED MISUSE OF CURRENT PROCEDURAL TERMINOLOGY CODES IS NOT THE TYPE OF INJURY TO THE SOVEREIGNTY OF THE UNITED STATES CONTEMPLATED BY THIS COURT IN *STEVENS*

A. CPT Codes Do Not Constitute a Legal Standard That the Government Has Jurisdiction to Enforce

In the *Stevens* decision, this court stated that, in order to have a valid claim for damages under the FCA, the Government must seek "compensation for, or [to] prevent[], the violation of a legally protected right." *Stevens*, 529 U.S. 765 at 772-773. The Government does not possess a legally protected right to interpret the CPT codes, or to prosecute an alleged misuse of the CPT codes, which it licenses on a commercial basis from the American Medical Association ("AMA").

A CPT code is a five-digit number identifying a medical service or procedure which is "consistent with contemporary medical practice," and is "performed by many physicians in clinical practice." *CPT Handbook*, (Fourth ed. 1992), pp. iii,x. CPT codes "simplify the reporting of services" for such purposes as third-party insurance reimbursement. *Id.* The CPT Codes were first developed by the AMA in 1966 and and are copyrighted by the AMA. The AMA's CPT Editorial Panel regularly updates CPT codes to reflect changes in medical practice. *Id.* at xii. Doctors are instructed to choose a code that "most accurately identifies the service performed." *CPT Handbook* at xi.

In 1983, HCFA contracted with the AMA to use CPT codes for the reporting of medical services and procedures performed by doctors for Medicare and Medicaid patients. http://aapsonline.org/aaps/medicare/hcfaama.txt (site viewed September 25, 2001). This contract, as amended, specifies that AMA licenses the CPT codes to HCFA. http://www.hcfa.gov/medlearn/amamend.htl (site viewed

September 25, 2001). Both parties disclaim liability stemming from the use of these codes. *Id.*

The current chairman of the AMA's CPT Editorial Panel, Dr. Tracy Gordy, testified on behalf of Dr. Krizek at trial. Trial Tr. (3/24/94) at 5-96. Dr. Gordy testified that the CPT codes are "guidelines" and not a legal mandate, stating "[i]t's only mandated, if you'll pardon my facetiousness, if you want to get paid under certain insurance carriers." *Id.* at 14.

Until recently, few federal courts have had reason to look at the CPT codes. In a case asserting that the CPT codes had passed into the public domain, a trial court concluded that "the CPT does not sound like, look like, nor act like a law." *Practice Management Information Corp. v. American Medical Association*, 877 F. Supp. 1386, 1388-1389 (C.D. Cal. 1994), *aff'd* 121 F.3d 516 (9th Cir. 1997), *modified* 133 F.3d 1140 (9th Cir. 1998), *cert. denied* 119 S. Ct. 40 (1998).

In the context of the Medicare and Medicaid programs, regulations binding on doctors must be promulgated by the Secretary of Health and Human Services ("HHS") in a formal manner, after announcement in the Federal Register and consideration of comments by interested parties. *Abbot Laboratories v. Gardner*, 387 U.S. 136, 150 (1967). The Secretary of HHS has taken the explicit position that "the adoption of the CPT codes [by HCFA] in 1983 was not a rule within the meaning of the Administrative Procedure Act." *American Society of Dermatologists v. Shalala*, 962 F. Supp. 141, 143-149 (D.D.C. 1996), *aff'd* 116 F.3d 941 (D.C. Cir. 1997). As privately copyrighted descriptors of services which function primarily as a billing convenience, CPT codes have not passed into the public domain and do not constitute binding legal requirements for the content of a doctor's patient treatment session.

In fact, CPT codes are not even mentioned in HCFA's requirements regarding claim submission to the Medicare and Medicaid programs. 42 C.F.R. 424.32, App. 87a-88a. Therefore, alleged CPT misuse by a doctor cannot constitute the type of sovereign injury to support standing under the FCA that

this court contemplated in the *Stevens* decision.

B. CPT Code Selection is Not Material to HCFA's Decision to Pay for a Doctor's Services Under Medicare and Medicaid Contracts

Fraud statutes generally require that an alleged falsity be material. *Neder v. United States*, 527 U.S. 1, 4, 22-23 (1999). The FCA, also a fraud statute, is no different. *United States ex rel. Berge v. Bd. of Trustees of Univ. of Alabama*, 104 F.3d 1453, 1460 (4th Cir. 1997), *cert. denied* 522 U.S. 916 (1997). To be material, a statement must have a "natural tendency to influence agency action or [be] capable of influencing agency action." *Berge*, 104 F.3d 1453 at 1460.

This materiality requirement in relation to FCA prosecutions has been espoused by the Solicitor General, who has stated that "a claim is 'false or fraudulent' ... whenever it misstates facts bearing on the claimant's *entitlement to payment*." *See Hughes* Government Amicus Brief at 25-26. Because the length of a treatment session is not material to HCFA's decision to pay a doctor for treating a Medicare or Medicaid patient, the District Court incorrectly based Dr. Krizek's liability on his CPT code selection.

1. Time is Not a Decisive Factor in Reimbursement for Medical Services Under Medicare and Medicaid.

The heart of the District Court's judgment against Dr. and Mrs. Krizek is the court's unquestioning acceptance of the Government's premise that psychiatric CPT codes used by the petitioners contain minimum treatment time requirements. *United States v. Krizek*, App. 66a. Yet such requirements are not articulated in the codes themselves, and the Secretary of HHS has expressly disavowed such an official interpretation, based on broader program goals:

> [T]ime should be viewed as a supplement, secondary to content descriptors. We believe that basing coding on time alone would be inequitable to efficient physicians...if actual times were used...this system could reward some physicians who simply took longer than necessary to perform a service, either because they were inefficient or they had slack time in their practices or both. 55 Fed. Reg. 36178, 36196-36198 (1990).

The reimbursement rates for the psychiatric CPT codes used by Dr. Krizek, and reimbursement rates for the "hospital visit" codes that the Government claimed that Dr. Krizek should have billed under instead, are almost identical. Trial Tr. (3/28/94) at 74-80. Which code Dr. Krizek billed under, as long as it reasonably accurately described the service that he performed, was not material to whether the Government would pay him. Trial Tr. (3/21/94) at p.51. Dr. Krizek did not contract with the Government to be an hourly wage worker; rather, he was entitled to payment for each patient treatment service. More importantly, the Government presented the District Court with a false choice. Pennsylvania Blue Cross/Blue Shield, the Government's agent which processed Dr. Krizek's reimbursement claims, required psychiatrists to bill under psychiatric codes, rather than hospital visit codes, for psychiatric hospital visits, and did not pay for both services on the same day for the same patient, forcing a doctor to "bundle" all of his or her services under one code. Trial Tr. (3/21/01) at 123-124; *United States v. Krizek*, App. 61a, 68a.

C. CPT Code Selection Does Not Further the Government's Policies and Goals Under Medicare and Medicaid

This court has described the Medicare program as having "a purpose and design above and beyond point-of-sale patient care," because "Medicare is designed to the end that the Government receives not only reciprocal value from isolated

transactions but also long-term advantages from the existence of a sound and effective health care system for the elderly and disabled." *Fischer v. United States*, 529 U.S. 667, 680-681 (2000). The Solicitor General has similarly emphasized that "recognition of the [principle of 'injury to the federal *program*'] ... is of central importance in enforcing compliance with conditions imposed by the government upon the receipt of public funds" in prosecutions under the FCA. *Hughes* Government Amicus Brief at 28.

Petitioners contend that putting Dr. Krizek out of business, and ultimately preventing him from treating patients, by accusing him of fraud under the FCA for billing under one CPT code rather than another, for medical care that he *actually provided*, not only does not serve the goals of the Medicare and Medicaid programs, but in this case, has actually blatantly undermined these goals.

III. THE STATUTORY SCHEMES OF THE SOCIAL SECURITY ACT AND RELATED MEDICARE AND MEDICAID LEGISLATION, AS WELL AS OF THE FALSE CLAIMS ACT, PRECLUDE THE GOVERNMENT FROM SEEKING A REMEDY OF RESTITUTION IN UNJUST ENRICHMENT

A. The Social Security Act and Related Medicare and Medicaid Legislation Provide for Administrative Mechanisms to Recoup Alleged Overpayments to Doctors

This court has long stood for the proposition that "where a statute creates a right and provides a special remedy, that remedy is exclusive." *U.S. v. Babcock*, 250 U.S. 328, 331 (1919). The Social Security Act and related legislation ("SSA") govern the "uniquely Federal interests" in the relationship between the Federal Government and a doctor with whom it contracts to treat Medicare and Medicaid patients. *Boyle v. United Technologies Corp.*, 487 U.S. 500, 504 (1988). By

means of these Medicare and Medicaid statutes and regulations, Congress has "occupied the field through the establishment of a comprehensive regulatory program supervised by an expert administrative agency," the Health Care Financing Administration ("HCFA").[4] *See Milwaukee v. Illinois*, 451 U.S. 304, 317 (1980).

When HCFA determines that a doctor contracting with it has been overpaid for his or her services, it has ample administrative mechanisms for recouping such funds. *See, e.g.* 42 C.F.R. Ch IV, Subpart C, 405.301 *et seq.*, App. 85a-86a. Pursuant to its own regulations, HCFA must first attempt to recoup this amount from the contracting doctor; if this attempt is unsuccessful, HCFA must attempt to recoup this amount from the program beneficiary who has benefitted from the doctor's service. 42 C.F.R. 405.350-351, App 85a-86a.

For reasons that are unclear, HCFA chose not to notify Dr. Krizek and attempt to recoup any allegedly overpaid sums from the petitioners, and instead referred this case to the Attorney General for prosecution. The District Court's unjust enrichment award has the anomalous effect of judicially mandating a recoupment for the Government that HCFA *itself* did not choose to pursue under its own comprehensive regulatory scheme.

B. The False Claims Act is a Comprehensive Remedial Statute Which Permits the Government to Prosecute a Doctor For Filing Allegedly Fraudulent Claims to Medicare and Medicaid

When HCFA determines that it has lost money due to

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[4] HCFA, a division of the U.S. Department of Health and Human Services, was established by Congress in 1977. *See* 42 Fed Reg. 13262 (1977). HCFA has recently been renamed the "Centers for Medicare and Medicaid Services," but will continue to be referred to as HCFA for the purpose of this petition, which concerns medical care rendered in 1986-1992.

fraud, it may refer the matter for prosecution under the Civil Monetary Penalties Act, a criminal law with a "knowing" scienter requirement, which is part of the comprehensive SSA statutory remedial scheme. 42 U.S.C. 1320a-7a. Given the ample statutory tools at HCFA's disposal for recouping funds *and* pursuing fraud, it may appear unnecessary for the Government to seek remedies outside of the SSA statutory scheme. However, when HCFA refers a matter of alleged Medicare and Medicaid fraud to the Department of Justice, the Attorney General may, in fact, choose to reach outside the SSA statutory scheme and bring a lawsuit against the doctor under the FCA, as he has done in this case. *See Peterson v. Weinberger*, 508 F.2d 45, 52 (5th Cir. 1975), *cert. denied* 423 U.S. 830 (1975); *accord United States v. Mackby*, 261 F.3rd 821, 826 (9th Cir. 2001); S. Rep. No. 99-345 at 9, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274 (a false claim for Medicare reimbursement is actionable under the FCA).

The FCA is another comprehensive statute that is a "form of long-arm statute," S. Rep. 99-345, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5297, which is "all-embracing in scope [and] national in purpose." *Stevens*, 529 U.S. 765 at 791 (Stevens, J. dissenting). Because of the comprehensive nature of the civil FCA statute, the Government is similarly foreclosed from receiving a remedy under the common law of unjust enrichment based on conduct underlying the Government's FCA claim.

C. A Remedy in Unjust Enrichment is Incompatible with the Federal Interests Reflected in the Social Security Act and the False Claims Act, and Conflicts with This Court's Decision in *Buckman Company v. Plaintiffs' Legal Committee*

Recently, in *Buckman Company v. Plaintiffs' Legal Committee*, this court examined a statute similar in scope to the SSA. 121 S. Ct. 1012 (2001). *Buckman* involved allegations of fraud regarding medical equipment, brought outside the scheme of the relevant remedial statute. This court held that such fraud

claims were precluded by federal law, primarily because the "federal statutory scheme amply empowers the [agency] to punish and deter fraud [committed] against the agency," but also because it is the relevant federal *agency* that must "achieve a somewhat delicate balance of statutory objectives." *Buckman*, 121 S. Ct. 1012 at 1017.

In *Buckman*, the relevant agency's "mission" was "to regulate...without directly interfering in the practice of medicine." *Id.* Similarly, the SSA directly prohibits Federal "supervision or control over the practice of medicine." 42 U.S.C. 1395, App. 84a.

This court explicitly recognized in *Buckman* that certain medical "decisions [are] statutorily committed to the discretion of health care professionals" and that the relevant agency is in the best position to "police fraud consistently with the Agency's judgment and objectives" *without* "intruding" on medical decision-making. 121 S. Ct. 1012 at 1018; 42 U.S.C. 1395, App. 84a. Petitioners posit that their case presents precisely the worst-case scenario feared by this court in the *Buckman* case. In making an award of restitution in unjust enrichment, the District Court substituted its own judgment for that of HCFA regarding what a "proper" medical treatment is, and allowed its own notions of the equities involved to override Dr. Krizek's medical judgment. *United States v. Krizek*, App. 63a.

The District Court's award of restitution in unjust enrichment, outside of the comprehensive statutory schemes of either the SSA or of the alternate scheme of the FCA, threatens a doctor's professional freedom to make medical decisions. Moreover, the award subverts a more fundamental legal right. It is a basic principle that "when the United States enters into contract relations, its rights and duties...are governed generally by the law applicable to contracts between private individuals." *United States v. Winstar Corp.*, 518 U.S. 839, 895 (1996). Instead of holding the Government to the terms of its contract with Dr. Krizek, the District Court, by interposing its own view of acceptable medical services, in effect has permitted the Government to deprive Dr. Krizek of the benefit of his bargain,

even though the Government has received precisely the medical services to Medicare and Medicaid beneficiaries that it contracted for.[5]

In creating its own *post facto* standard of a nine-hour medical workday, the District Court has in essence declared that Dr. Krizek breached the terms of an "hourly wage" contract that he never agreed to. The District Court bifurcated liability in this case, creating one standard for unjust enrichment liability, and another standard for FCA liability. *United States v. Krizek*, App. 48a. Nevertheless, both forms of liability stem from the same medical treatments provided under a federal contract. Since, as the District Court found, Dr. Krizek provided medically necessary patient treatment as claimed and caused no damages under the FCA, then he logically did not unjustly enrich himself, either.

Whether Dr. Krizek has breached the FCA, *and* whether he has been "unjustly enriched," both "depend...on the duties imposed on [Dr. Krizek] by the [contract], measured against [his] compliance thereunder." *United States v. Bankers Insurance Co.*, 245 F.3rd 315, 325 (4th Cir. 2001). The terms of this contract were subject to construction under the SSA, and not under the District Court's extraneous standards. This court has recently stated that "conflict is imminent when two separate remedies are brought to bear on the same activity." *Crosby v. National Foreign Trade Council*, 120 S. Ct. 2288, 2298 (2000). The District Court's unjust enrichment award has created just such a conflict. The contract between Dr. Krizek and HCFA is governed by the comprehensive remedial scheme of the SSA. Congress has stated that it is also subject to challenge under the comprehensive remedial scheme of the FCA, S. Rep. No. 99-

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[5] Under basic contract law principles, an injured party may receive restitution only upon "total breach" by the other party which substantially impairs the value of the contract to the injured party. Restatement (Second) of Contracts 243 (1979) *See also discussion in Mobil Oil v. United States*, 530 U.S. 604 (2000)(Stevens, J. dissenting)(a party is entitled to restitution only if the other party substantially breached a contract.)

345, at 9, *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274, which imposes a burden on the Government to prove actual damages. The District Court's award of restitution in unjust enrichment conflicts with and distorts these remedial schemes, and must therefore be precluded by them.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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Dated: October 17, 2001

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 00-5385

United States of America,

Appellee,

v.

George O. Krizek, M.D. and Blanka H. Krizek,

Appellants.

April 17, 2001, Filed

PRIOR HISTORY: 93cv00054.

DISPOSITION: Motion for leave to file a motion for oral argument denied. Motion for summary affirmance granted. Appellee's request that post-judgment interest calculated from December 20, 1995 granted. Court's own motion, that the case remanded to the district court to determine the amount of post-judgment.

COUNSEL: For UNITED STATES OF AMERICA, Plaintiff - Appellee: R. Craig Lawrence, Rudolph Contreras, Assistant U.S. Attorneys, Wilma Antoinette Lewis, U.S. Attorney's Office, (USA), Washington, DC.

For GEORGE O. KRIZEK, M.D., BLANKA H. KRIZEK, Defendants - Appellants: Monika Krizek Griffis, Law Office of Monika Krizek Griffis, Washington, DC.

JUDGES: BEFORE: Williams, Ginsburg, and Randolph, Circuit Judges.

ORDER

Upon consideration of the motion for summary affirmance, theresponse thereto, and the reply; the motion for leave to file a motion for oral argument; the lodged motion for oral argument; and the notice of recent decision, and the supplement thereto, it is

ORDERED that the motion for leave to file a motion for oral argument be denied. The motion is, in effect, a motion for leave to file a surreply. The lodged motion for oral argument offers nothing new for the court to consider. It is

FURTHER ORDERED that the motion for summary affirmance be granted. The merits of the parties' positions are so clear as to warrant summary action. *See Taxpayers Watchdog, Inc. v. Stanley*, 260 U.S. App. D.C. 334, 819 F.2d 294, 297 (D.C. Cir. 1987) (per curiam); *Walker v. Washington*, 201 U.S. App. D.C. 82, 627 F.2d 541, 545 (D.C. Cir.) (per curiam), cert. denied, 449 U.S. 994 (1980). Appellee has standing to bring this case. *See Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 146 L. Ed. 2d 836, 120 S. Ct. 1858, 1862 (2000). Appellants failed to raise the issues of due process and excessive fines in the district court, and there are no exceptional circumstances warranting the consideration of those issues for the first time on appeal. *See District of Columbia v. Air Florida, Inc.*, 243 U.S. App. D.C. 1, 750 F.2d 1077, 1084 (D.C. Cir. 1984). Furthermore, appellants have waived their challenges to the award for unjust enrichment because they failed to raise them in their previous appeals. *Hartman v. Duffey*, 319 U.S. App. D.C.169, 88 F.3d 1232, 1236 (D.C. Cir. 1996). It is

FURTHER ORDERED that appellee's request that post-judgment interest be calculated from December 20, 1995 be granted. Appellants failed to respond to appellee's request, and have therefore waived any objection to the request. It is

FURTHER ORDERED, on the court's own motion, that the case be remanded to the district court to determine the

amount of post-judgment interest due appellee, including whether appellee should be awarded post-judgment interest on the entire amount of the ultimate award or some portion thereof for each relevant time period.

The Clerk is directed to withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing or petition for rehearing en banc. See Fed. R. App. P. 41(b); D.C. Cir. Rule 41.

Per Curiam

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITED STATES OF AMERICA,
APPELLANT/CROSS-APPELLEE

v.

GEORGE O. RIZEK, M.D. AND BLANKA H. KRIZEK,
APPELLEES/CROSS-APPELLANTS

No. 98-5455, Consolidated with No. 98-5456

September 8, 1999, Argued
October 5, 1999, Decided

PRIOR HISTORY: Appeals from the United States District Court for the District of Columbia. (No. 93cv00054).

DISPOSITION: Remanded for further proceedings.

COUNSEL: Mark E. Nagle, Assistant U.S. Attorney, argued the cause for appellant/cross-appellee.

Wilma A. Lewis, U.S. Attorney, R. Craig Lawrence and Dara A. Corrigan, Assistant U.S. Attorneys, were on the briefs.

Jeffrey Bossert Clark argued the cause for appellees/cross-appellants. With him on the briefs was Karen N. Walker.

JUDGES: Before: WALD, SILBERMAN and TATEL, Circuit Judges. Opinion for the Court filed by Circuit Judge TATEL.

OPINION BY: TATEL

OPINION: TATEL, *Circuit Judge*: After a three-week bench trial, the district court found that defendants, a psychiatrist and his wife/secretary, submitted claims for reimbursement for services performed for Medicare/Medicaid patients in violation of the False Claims Act. Because it was impossible to identify precisely which claims were fraudulent, the district court held defendants liable only for claims submitted on days they billed for more than twenty-four hours of work, and then only for those patient sessions that exceeded the twenty-fourth hour. Following an appeal to this court, we remanded to the district court to consider additional evidence from the Government and to recalculate the number of false claims based on a new definition of "claim." Finding the district court's actions on remand inconsistent with our mandate, we again remand for further proceedings.

I

Dr. George Krizek practiced psychiatry in Washington, D.C. His wife Blanka functioned as his secretary and was responsible for his billing. In 1993, the Government filed a civil complaint alleging that for six years the Krizeks had submitted claims for reimbursement for services provided to Medicare/Medicaid patients in violation of the False Claims Act, 31 U.S.C. §§ 3729-31. After a three-week bench trial, the district court found that the Krizeks had submitted claims for reimbursement "when Dr. Krizek could not have spent the requisite time providing services...." *United States v. Krizek*, 859 F. Supp. 5, 12 (D.D.C. 1994). Ruling that the Krizeks would be "presumed liable" under the False Claims Act for all claims they submitted in excess of nine hours per day, the district court referred the case to a Special Master to determine the number of false claims in excess of the nine-hour benchmark and to calculate the precise amount of the Krizeks' liability.

In the proceedings before the Special Master, the Government introduced into evidence all "HCFA 1500"

forms that the Krizeks had submitted to the Government for reimbursement. HCFA 1500 forms serve as invoices for billing Medicare and Medicaid: they must contain the doctor's name, the patient's name, the dates services were provided, and a five-digit code identifying each service provided to a particular patient, called a "CPT code." For example, the CPT code 90844, which Dr. Krizek used frequently, indicates an individual psychotherapy session lasting approximately forty-five to fifty minutes. While a single HCFA form includes services for only one patient, it may include services rendered to that patient on multiple days.

HCFA 1500 forms contain only the CPT codes that Dr. Krizek billed, not the actual time he spent with each patient. As a result, the Special Master had to fashion a methodology to convert the codes into time periods in order to determine the number of hours the doctor actually billed each day. Because of the large number of claims (some days Dr. Krizek saw upwards of fifty patients), changing the assumptions of how much time each code represented would materially affect the total time billed for the entire day. Largely accepting the Government's proposed methodology for translating CPT codes into time periods, the Special Master attributed to each code the amount of time at the low end of its stated range (unless the doctor had indicated a different time period on the form). For the frequently used CPT code 90844, for example, the Special Master assumed a forty-five-minute session, the low end of the forty-five to fifty-minute range. For CPT code 90843, another frequently used code, this one having a twenty to thirty-minute range, the Special Master assumed twenty minutes. Using this methodology and determining that each CPT code represented a "claim" under the False Claims Act, the Special Master identified 264 days on which the Krizeks billed for more than nine hours, amounting to 1,149 false claims. Multiplying by $5,000, the minimum fine per claim under the False Claims Act, the Special Master calculated a total fine of $ 5.7 million.

The district court accepted the Special Master's findings of fact. *United States v. Krizek*, 909 F. Supp. 32, 33 (D.D.C. 1995) ("*Krizek II*"). Seemingly moved by the enormity of the $ 5.7 million fine, however, the district court abandoned the nine-hour presumption, ruling instead that defendants could only be liable under the False Claims Act for claims submitted on days on which they billed for more than twenty-four hours of work, and then only for those patient sessions exceeding the twenty-fourth hour. *Id.* At 34. Applying this new benchmark, the Special Master identified three days on which the Krizeks billed more than twenty-four hours; on those days, he found a total of eleven false claims. The district court, assessing the $ 10,000 maximum fine under the False Claims Act for each violation, entered judgment against the Krizeks for $110,000, plus unjust enrichment damages of $47,100. *Id.* Both parties appealed.

In *United States v. Krizek*, 324 U.S. App. D.C. 175, 111 F.3d 934 (D.C. Cir. 1997) ("*Krizek III*"), this court affirmed the Krizeks' liability under the False Claims Act but remanded for further proceedings with respect to the calculation of the number of violations and the penalties to be assessed. In so doing, *Krizek III* resolved two issues central to the current appeal. First, it held that "the District Court's use of a twenty-four hour presumption, having earlier announced its intent to use nine hours as the benchmark, prejudiced [the Government's] prosecution of the claim." 111 F.3d at 938. In this regard, the court noted that the Government, in reliance on the district court's nine-hour benchmark, had adopted conservative estimates regarding the time attributable to each CPT code and declined to pursue discovery of Dr. Krizek's billings for non-Medicare/Medicaid patients. *Id.* Second, *Krizek* III rejected the conclusion of both the Special Master and the district court that each individual CPT code on a HCFA 1500 form represents a "claim" under the False Claims Act, holding instead that each HCFA 1500 form is a claim. *Id.* at 939-40. For example, if a particular

HCFA 1500 form identifies five services performed by Dr. Krizek for a single patient on five separate days, the form could constitute at most one false claim.

On remand, the district court ordered the Krizeks to give the Government their records of private pay patients seen on the ten "worst" days--those days the Government identified as reflecting the Krizeks' most egregious billing practices. Citing the "meager fruit" to be expected from further discovery when the ten worst days plus fifteen additional days voluntarily provided by the Krizeks yielded only two additional days on which the Krizeks had billed more than twenty-four hours, the district court rejected the Government's request for additional discovery. *United States v. Krizek*, 7 F. Supp. 2d 56, 58 (D.D.C. 1998) ("*Krizek IV*"). At the same time, the district court refused to find False Claims Act liability on the two additional twenty-four-hour days because "the Government cannot prove that the claims in excess of 24 hours were the ones billed to Medicare/Medicaid as opposed to those billed to non-Medicare/Medicaid private patients." *Id.* Turning to *Krizek III's* definition of "claim," and reasoning that "on the evidence submitted, the Government has failed to establish which of the claims, under the new definition, are the ones in excess of the 24 hour presumption," the district court found insufficient evidence in the record to establish more than one false claim per day. *Id.* At 59. The district court fined the Krizeks $ 30,000, $ 10,000 for each false claim.

II

In this second appeal, again brought by both sides, the parties fundamentally misunderstand the limited scope of this court's remand in *Krizek III*. In their cross-appeal, for example, the Krizeks argue that *Krizek III's* direction to the district court to consider additional evidence regarding the conservative time assumptions the Government adopted in reliance on the nine-hour benchmark "reopened the methodological issue," allowing them to challenge the factual

underpinnings of the Special Master's calculations. Not so. *Krizek III's* remand rested on its express finding that the switch from a nine-hour to a twenty-four-hour benchmark prejudiced the Government's prosecution of its case. Krizek III intended nothing more than to give the Government an opportunity to revisit its assumptions, not to reopen all aspects of the Special Master's methodology.

We will not consider the Krizeks' cross-appeal for a second, equally important reason. Although they insist that they "challenged the government's methodology at every conceivable step," they failed to do so at one critical juncture: their original appeal to this court. *See Hartman v. Duffey*, 319 U.S. App. D.C. 169, 88 F.3d 1232, 1236 (D.C. Cir. 1996) ("We do not reach the merits of defendant's arguments on this issue because of the defendant's failure to pursue it in its prior appeal."), *cert. denied*, 520 U.S. 1240, 137 L. Ed. 2d 1048, 117 S. Ct. 1844 (1997).

Equally misconstruing *Krizek III's* limited remand, the Government faults the district court for failing to reconsider the twenty-four hour benchmark. Nothing in *Krizek III* entitled the Government to challenge that benchmark on remand. *Krizek III* assumed the validity of the twenty-four hour benchmark and remanded for the limited purpose of giving the Government an opportunity to revisit its assumptions. If this court had intended to require the district court to go beyond evaluating the Government's assumptions and to reconsider the twenty-four-hour benchmark, it would have done so directly, not as elliptically as the Government claims it did.

Although the twenty-four-hour benchmark is a closed matter in this litigation, we do think the Government has pointed out three respects in which the district court's actions are inconsistent with *Krizek III's* mandate: the district court refused to consider the Government's evidence regarding the conservative assumptions it adopted in reliance on the nine hour benchmark; it excluded time billed to Dr. Krizek's private pay patients from the calculation of twenty-four-hour

days; and it applied an incorrect methodology to determine the number of false claims over the twenty-four-hour benchmark. With respect to the first two issues, *Krizek III* could not have been clearer: "The government argues that the District Court's use of a twenty-four hour presumption, having earlier announced its intent to use nine hours as the benchmark, prejudiced its prosecution of the claim. We agree and remand for further proceedings." *Krizek III*, 111 F.3d at 938. To flesh out the nature of that prejudice, *Krizek III* directed the district court to (1) focus on the conservative assumptions the Government offered to determine how much time to allocate to each CPT code and (2) allow discovery of records of time billed to Dr. Krizek's private pay patients. *Id.*

Referring to the first of these tasks, *Krizek III* characterized the Government's time estimates as conservative, concluding that: "Considering the large number of claims submitted on any given day these assumptions may have had a material effect on the damages proved up by the government. However, because the damages were likely to be substantial already [using a nine-hour benchmark], the government chose not to proffer less generous approximations." *Id.* Notwithstanding *Krizek III's* clarity, the district court flatly refused to listen to the Government's arguments about its conservative assumptions, let alone to allow the Government to introduce additional evidence. When Government counsel raised the issue at a September 5 Status Call, the district court said: "You're dead on that issue. There is no--you're not going to now say, okay, it's 30 [minutes]. No, no. The Court of Appeals didn't say that. The Court of Appeals . . . indicated they accepted that." In response, Government counsel quoted the passages from *Krizek III* discussed above. "You've misread that," replied the district court.

> Don't mislead this Court, Mr. Hegyi. . . . You're misleading the Court now. That's not what it says. . . . All it says is that you were generous, and it doesn't say that I now go back and have to let you

> be less generous. . . . Look, Mr. Hegyi, I'm not going to argue with you any more. So let's go on. No, you're not going to continue with that because the Court of Appeals affirmed the Special Master and I'm not going to undo that work.

Instead of defending the district court's actions with respect to the Government's conservative assumptions, the Krizeks argue that the Government failed to preserve the issue for appellate review. The record demonstrates to the contrary. Not only did the Government twice bring the issue to the attention of the district court during the September 5 Status Call, but it reiterated its claim in written submissions to the district court: "The United States is aware that at the September 5, 1997 status conference the Court indicated it would not permit such a re-calculation. However, the United States includes this proposal out of an abundance of caution to prevent a possible future claim of waiver or abandonment by the Government." Given the district court's refusal to discuss the assumptions and particularly given its accusation that Government counsel was trying to mislead the court, we have no idea what more the Krizeks think the Government should have done (short of risking contempt) to preserve the issue for appeal.

To avoid any confusion about the scope of our remand from this appeal, we state our instructions with specificity. The district court must first allow the Government to submit additional evidence regarding its conservative assumptions. It should then consider whether the Government's evidence requires any change in the Special Master's calculation of the number of hours billed each day. Nothing in this remand "reopens" the methodological issues raised by the Krizeks in their cross-appeal. The Krizeks may respond to the Government's claim that its assumptions were too conservative in light of the twenty-four-hour benchmark, nothing more.

Krizek III's direction to the district court regarding the handling of private pay patients breaks down into two issues:

discovery regarding the Krizeks' billing of private pay patients and incorporation of private pay patients into the calculation of the number of hours billed each day. Beginning with the first issue, we disagree with the Government that the district court improperly restricted its discovery. Since the private pay records for the twenty-five worst days yielded only two additional twenty-four-hour days, the district court's conclusion that further discovery would not likely have identified any more was hardly an abuse of discretion. *See Food Lion, Inc. v. United Food and Commercial Workers Int'l Union*, 322 U.S. App. D.C. 301, 103 F.3d 1007, 1012 (D.C. Cir. 1997) ("[A] district court's decision to permit or deny discovery is reviewable only for an abuse of discretion.").

We do agree with the Government, however, that the district court's refusal to include time billed to private pay patients in the calculation of the number of hours the Krizeks billed per day was inconsistent with the *Krizek III* mandate. *Krizek III* stated: "Presumably, if the government had introduced evidence on [private pay] patients it could have established that the Krizeks billed in excess of twenty-four hours on more days than indicated by Medicare and Medicaid records alone." 111 F.3d at 938. Clearly implicit in this statement is the proposition that private pay patients be included in calculating twenty-four-hour days. Why else would *Krizek III* have ordered such discovery? Yet the district court refused to include private pay patients, explaining, "the Government cannot prove that the claims in excess of 24 hours were the ones billed to Medicare/Medicaid as opposed to those billed to non-Medicare/Medicaid private patients." *Krizek IV*, 7 F. Supp. 2d at 58. "The mere assumption that all hours exceeding the 24 hour benchmark were hours billed to Medicare/Medicaid," the district court said, "is insufficient to prove knowing or reckless conduct." *Id.* at 59.

In refusing to include private pay patients as required by *Krizek III*, the district court imposed on the Government a burden not required by the False Claims Act. The

Government does not have to "*prove* that the claims in excess of 24 hours were the ones billed to Medicare/Medicaid. " The False Claims Act requires only that the Government prove that the Krizeks acted "in reckless disregard of the truth or falsity of the information" they submitted to the Government, and that it do so not beyond a reasonable doubt, but "by a preponderance of the evidence." 31 U.S.C. §§ 3729(b)(3), 3731(c). Yet under the district court's reasoning, it would be virtually impossible for the Government to establish liability on any twenty-four-hour day that included private pay patients.

Particularly in view of the district court's exceptionally conservative twenty-four-hour benchmark--i.e., the Krizeks could be found liable only on days they billed for more than twenty-four hours of work, a physical impossibility--we think the False Claims Act preponderance standard is easily satisfied when any patient is seen beyond the twenty-fourth hour. Reinforcing this conclusion, an affidavit by a Government Special Agent lists several reasons for suspecting that the false claims were most likely the Medicare/Medicaid claims, including that many Medicare/Medicaid patients were being treated for severe psychiatric disorders and likely lacked the ability to monitor bills submitted on their behalf, that the private pay patients had an "active self-interest" in ensuring that the Krizeks billed them properly, and that the Krizeks had a greater incentive to keep (and therefore not defraud) their more lucrative private pay patients.

In sum, *Krizek III's* inclusion of private pay patients has two implications for the calculation of the number of false claims, implications the district court must account for on remand. First, it adds two more twenty-four-hour days, bringing the total to five. Second, it increases the number of false claims on the three original twenty-four-hour days.

This brings us to the final respect in which the district court's actions were inconsistent with *Krizek III*. *Krizek III* required the district court to recalculate the number of false claims submitted by the Krizeks in light of the court's

redefinition of "claim" as the HCFA 1500 form itself, not the individual CPT codes on the forms. 111 F.3d at 940. Although determining the number of false claims requires nothing more than calculating how many forms actually contained fraudulent entries, the district court simply concluded that three twenty-four-hour days equals three false claims. The district court explained:

> On the evidence submitted, the Government has failed to establish which of the claims, under the new definition, are the ones in excess of the 24 hour presumption. The evidence merely establishes that on the 3 days in question, the Defendants billed in excess of 24 hours to Medicare/Medicaid. Based on this record, the Court can only conclude that on each of the 3 days, there was at least one false claim under the definition established by the Court of Appeals. . . . While there certainly could have been more than one form with a false statement submitted on each given day, there is insufficient proof in the record.

Krizek IV, 7 F. Supp. 2d at 59.

Again, we think the district court heightened the Government's burden of proof beyond the False Claims Act's preponderance standard. The Government need not prove which particular patient sessions occurred after the twenty-fourth hour. Indeed, both parties agree that would be an impossible task because records indicating the time of day Dr. Krizek saw particular patients do not exist.

Even defense counsel seems to agree that the district court's rationale for finding only three false claims is flawed, conceding at oral argument that the proper method of determining the number of false claims is to count the number of patient sessions after the twenty-fourth hour and then to eliminate any overlap among those sessions, i.e., instances in which the Krizeks billed on a single HCFA form more than one patient session occurring after the twenty-fourth hour.

To accomplish this simple task, the parties in the district court need do nothing more than utilize the methodology for calculating the number of false claims developed by the Special Master. The Special Master's methodology was employed by the district court in *Krizek II* and not appealed by the Krizeks. *Krizek III's* new definition of "claim" merely adds an additional step—the elimination of overlap.

We need not describe the Special Master's methodology here; his procedures and assumptions are fully explained in the record. Suffice it to say that his methodology, based on assumptions favorable to the Krizeks, identified which particular patient sessions occurred after the twenty-fourth hour and produced a total of eleven such sessions on the three original twenty-four-hour days. To calculate the number of false claims, all the district court needed to do on remand from *Krizek III*–and all it needs to do now–is eliminate any overlap among patient sessions occurring after the twenty-fourth hour that are billed on the same HCFA form. For example, if Dr. Krizek saw patient X after the twenty-fourth hour on two of the twenty-four-hour days, and billed both days on the same HCFA 1500 form, only one false claim occurred, not two.

Not surprisingly, the parties do not even agree about this simple mathematical calculation. Citing an affidavit by its Special Agent, the Government claims that there is no overlap among the eleven false claims found by the district court in *Krizek II*. Counsel for the Krizeks, who conceded at oral argument that the district court's reasoning was flawed, nonetheless claims that eliminating the overlap would yield the same result as the district court reached in *Krizek IV*-only three false claims. To support this proposition, counsel directed us to a chart in the record before the district court. As we read that chart, however, it speaks not to the overlap among the three twenty-four-hour days the district court originally identified, but to overlap among one of those three days and the two twenty-four-hour days the Government discovered when accounting for private pay patients. The chart, moreover, fails to employ the Special Master's

methodology for identifying which particular patient sessions occurred after the twenty-fourth hour.

The district court's task on remand is simple and mathematical. To determine the number of false claims, it must (1) use the Special Master's methodology to count the number of patient sessions that occurred after the twenty-fourth hour on the five twenty-four-hour days (the three original twenty-four-hour days plus the two additional twenty-four-hour days discovered on remand from *Krizek III*) and then (2) eliminate any overlap among those sessions.

III

This prosecution of a single doctor has now spanned over six years. It has consumed three weeks of trial, several days of hearings before the Special Master and the district court, two fully briefed, fully argued appeals, and five published opinions (three by the district court and two by this court). The five days on which the false claims were made occurred over twelve years ago. According to defense counsel, Dr. Krizek no longer practices medicine and is dying of cancer.

It is time for the parties to stop refighting battles long-ago lost and for the district court to bring this prosecution to an expeditious close. To facilitate that goal, we repeat our instructions. (1) The district court must permit the Government to introduce evidence regarding its conservative assumptions and then consider whether to change any of the Special Master's assumptions in light of this evidence. (2) The district court must include private pay patients in its recalculation of the number of hours the Krizeks billed on each of the five twenty-four-hour days. (3) Then, using the methodology adopted by the Special Master, the district court must determine the number of false claims by recalculating the number of patient sessions after the twenty-fourth hour on each of the five twenty-four-hour days and eliminating any overlap. We fully expect that these simple steps will bring this prosecution to a long-deserved end.

The clerk is directed to issue the mandate forthwith.

So ordered.

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 93-00054

UNITED STATES OF AMERICA,

Plaintiff,

v.

George O. Krizek, ET AL,

Defendant

July 14, 1998, Decided
July 15, 1998, Filed

COUNSEL: For UNITED STATES OF AMERICA, plaintiff: Bruce R. Hegyi, U.S. ATTORNEY'S OFFICE, Washington, DC.

For GEORGE O. KRIZEK, M.D., BLANKA H. KRIZEK, defendants: Karen Natalie Walker, Jeffrey Bossert Clark, KIRKLAND & ELLIS, Washington, DC.

For GEORGE O. KRIZEK, M.D., BLANKA H. KRIZEK, defendants: Monika Blanche Krizek, Washington, DC.

For GEORGE O. KRIZEK, M.D., BLANKA H. KRIZEK, defendants: Joseph Nathan Onek, Paula Joanne Desio, CROWELL & MORING, L.L.P., Washington, DC.

For WILLIAM H. BRIGGS, JR., special master: William Holt Briggs, Jr., ROSS, DIXON & MASBACK, L.L.P., Washington, DC.

For THE WASHINGTON PSYCHIATRIC SOCIETY, intervenor: Armin Ulrich Kuder, KUDER, SMOLLAR & FRIEDMAN, P.C., Washington, DC.

JUDGES: Stanley Sporkin, United States District Judge.

OPINION BY: Stanley Sporkin

MEMORANDUM OPINION

This matter comes before the Court on remand from the Court of Appeals' decision in this case, *United States v. Krizek*, 324 U.S. App. D.c. 175, 111 F.3d 934 (1997) ("*Krizek III*"). Dr. Krizek was a psychiatrist who practiced in Washington, D.C. for over twenty years. On January 11, 1993, the Government brought suit against Dr. George Krizek and his wife, seeking over $ 80 million in penalties and damages on the basis of false Medicare and Medicaid reimbursement claims. The Government sought damages on the basis of unjust enrichment and violations of the False Claims Act.

The False Claims Act, 31 U.S.C. § 3729 (a), requires that violators be held liable for triple the amount unjustly paid to them and fined between $ 5,000 and $ 10,000 for each claim in violation of the Act. The Act is violated when one "knowingly" submits a false claim to the Government. See 31 U.S.C. § 3729 (b). A defendant may be deemed to have "knowingly" violated the Act if he or she acted with "reckless disregard as to the truth or falsity of the information." *Id.*

After hearings and related proceedings, including supplemental hearings before a special master, this Court issued two memorandum opinions and orders. *See United States v. Krizek*, 859 F. Supp. 5 (D.D.C. 1994)("Krizek I"); *United States v. Krizek* 909 F.Supp. 32 (D.D.C. 1995) ("Krizek II"). Initially, the Court held all claims submitted for a single day in excess of 9 hours would be presumed to be in violation of the False Claims Act. *See Krizek I*, 859

F.Supp. at 12. On the basis of this presumption, the Government presented evidence and the special master found that on 264 days, the Defendants submitted more than 9 hours worth of claims. *Krizek II*, 909 F. Supp. At 33. Based on the special master's findings, the Court concluded that the Defendants submitted 1,149 claims for which they were paid $ 47,105.39, and it awarded this sum to the Government as unjust enrichment. *Id.* However, for the False Claims Act violations, which required knowing or reckless conduct, the Court decided that the 9-hour presumption was insufficient to prove the requisite intent. The Court set a 24-hour presumption "so that there can be no question as to the falsity of the claims." *Id.* At 34. Based on the special master's findings, there were three days in which the Defendants billed Medicare/Medicaid in excess of 24 hours in a day. There were a total of 11 claims in excess of the 24-hour presumption. When multiplied by $ 10,000 for each claim in violation of the False Claims Act, the Defendants were held liable to the Government for $ 110,000. Combined with the unjust enrichment damages, the Court awarded $ 157,105.39 to the Government. The Court also required the Krizeks to pay $11,000 for the costs of the special master. See *Krizek II*, 909 F. Supp. At 34.

Both the Government and the Defendant appealed. The Court of Appeals affirmed most of the Court's rulings, but reversed on two issues. First, the Court of Appeals held that each line item (or code) on a HCFA 1500 form[1] did not constitute a separate false claim. Second, the Court of Appeals held that the parties should have been given the opportunity to present evidence after the adoption of the 24-hour standard. The Court of Appeals' instructions were clear. This Court was to permit the parties to present additional

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[1] The HCFA form is a form containing claims for reimbursement from Medicare/Medicaid.

evidence regarding whether the Defendants submitted claims in excess of the 24-hour standard fixed by the Court:

> While this higher standard may have been permissible, the District Court erred in issuing judgment based on the new presumption without permitting the parties to introduce additional evidence. We do not hold, as urged by the government, that the District Court was prohibited from revisiting its earlier finding and replacing it with twenty-four hour presumption. See *Krizek II*, 909 F, Supp. At 34.

I. Government's Request for Discovery

At the first status conference the Court held on remand, the Government made demands for discovery that were staggering and uncalled for. First, the Government demanded that the Defendants disclose all of the names of Dr. Krizek's private pay patients. In light of the questionable relevance of the names of these patients as well as the need to protect the privacy of individuals seeking psychiatric care, the Court refused to order that the names of the patients be divulged. Instead, the Court permitted the Government information on how many hours were billed to private pay patients on particular days. See Transcript, September 9, 1997, at 37-38.

Second, the Government requested that the Defendants provide all information about billing to private pay patients for all 1825 days in question. The Court, in the interest of economy, limited discovery to 10 days, of the Government's choosing, which would represent the most egregious billing practices by the Defendants. The Court indicated it would permit additional discovery if the evidence from these days suggested that more discovery would prove fruitful. The Government submitted a discovery request to the Defendants for 25 days. Although the Court limited the Government to 10 days, the Defendants provided responses for all 25 days. Nevertheless, the Government remains unsatisfied; not only does it request discovery for all 1825 days, but it also asks for numerous depositions. This Court concludes that it granted the Government more than a reasonable amount of discovery.

The Government's search of the 25 most egregious days yielded only two days involving potential False Claims Act violations under the 24-hour presumption. The meager fruit of any further discovery is clearly outweighed by the vast time, expense, and burden on the Defendants. The Court of Appeals did not remand this case so that the Government could go on a fishing expedition.

Third, the Government claimed that the Court should order more discovery regarding unjust enrichment liability. This request was clearly uncalled for since the remand only concerned additional proof to be submitted regarding the 24-hour presumption on the False Claims Act violations. Accordingly, the Court denied the Government's request.

Finally, the Government requested discovery concerning the appropriateness of the 24-hour presumption. As with the unjust enrichment issue, the Court of Appeals did not require that this Court revisit the 24-hour presumption. The Government, by continuing to demand that almost every aspect of this case be reopened, severely misreads the Court of Appeals' narrow remand.

II. Post-Remand Proof

The Government now submits its new proof based upon the private pay patient information for the 25 days it requested. After all the time and expense necessary to produce that information, the Government has discovered only two days where the combined hours worked (for Medicare/Medicaid patients as well as private paid patients) exceeded the 24-hour presumption. The Government claims to have identified additional false claims on the original three days. The Defendants submitted proof stating that the Government's calculations on the three initial days as well as the two additional days were in error. According to the Defendants, on no day were the total hours worked over 24 hours.

The problem with the Government's argument is that the Government cannot prove that the claims in excess of 24

hours were the ones billed to Medicare/Medicaid as opposed to those billed to non-Medicare/Medicaid private patients. In order to establish a False Claims Act violation, the Government must prove that Dr. Krizek's improper claims were made knowingly or recklessly. But in a day involving an excess of 24 hours of billing, which includes both private pay claims and Medicare/Medicaid claims, the Government must prove that it was the Medicare/Medicaid claims that were fraudulent. The Government argues that the Court must find that the improper claims in excess of the 24 hour presumption should be assumed to be Medicare/Medicaid claims rather than private pay claims. However, there is simply no way to know this based upon the evidence presented. As the Special Master correctly recognized, "there are no records that reflect when a particular service was performed; thus it is impossible to identify the services allegedly performed in the first [24] hours of any day." Special Master's Report, at 8 n.3. The mere assumption that all hours exceeding the 24 hour benchmark were hours billed to Medicare/Medicate is insufficient to prove knowing or reckless conduct.

In light of the Court of Appeals decision that each line item does not constitute a separate claim, this Court must revisit its finding that there were 11 false claims in excess of the 24 hour presumption. The Court of Appeals determined that the FCA is violated only when an entire HCFA 1500 form containing a false statement is submitted. Even if the same HCFA 1500 form contains more than one false statement, the Court of Appeals held it is still only a single violation of the FCA. On remand, the Government claims that each of the original 11 false claims were submitted on separate HCFA 1500 forms. Therefore, it alleges that each is a separate "claim" as defined by the Court of Appeals.

This Court is not persuaded. If the Government's assertion were true, then the Court of Appeals would have resolved a purely hypothetical issue. This cannot be the case. The problem with the Government's position is that it has failed to acknowledge that the new definition affects all of the

claims on the 3 days Defendants billed in excess of 24 hours to Medicare/Medicaid. Under the definition adopted by this Court, it did not matter when, during the day, Defendants billed each claim. The Court merely added the total hours of claims billed to Medicare/Medicaid on each given day until it reached a total of 24 hours. Then, the Court counted the number of claims on each given day in excess of the 24-hour presumption. Under the Court of Appeals' definition of "claim" which now controls, there are claims under the old definition on the 3 days in question which would now be considered a single false claim rather than multiple false claims. Because the new definition results in overlapping claims, this creates a complication in the Government's case that it has not acknowledged. The Government must now prove whether these overlapping claims occurred before or after the 24th hour in the day. The Government takes the position that this Court should just assume that the original 11 claims occurred after the 24th hour. Of course, this is because these particular 11 claims, as opposed to the others, have no overlap and thus are not negatively affected by the Court of Appeal's new definition. Yet the Court cannot make this assumption in favor of the Government. On the evidence submitted, the Government has failed to establish which of the claims, under the new definition, are the ones in excess of the 24 hour presumption. The evidence merely establishes that on the 3 days in question, the Defendants billed in excess of 24 hours to Medicare/Medicaid. Based on this record, the Court can only conclude that on each of the 3 days, there was at least one false claim under the definition established by the Court of Appeals. In other words, the Court can only infer that on each of the days, at least one of the HCFA 1500 forms contained a false statement. While there certainly could have been more than one form with a false statement submitted on each given day, there is insufficient proof in the record. Accordingly, based upon the Court of Appeals' mandate, this

Court concludes that only 3, not 11, claims were submitted in excess of the 24 hour presumption. [2]

The Defendants have also submitted post-remand proof. They claim that on the two additional days submitted by the Government, their calculations reveal that the Defendants did not bill in excess of 24 hours. Additionally, the Defendants offer evidence that they did not bill in excess of 24 hours for the three original days in which the Court found they were liable for 11 False Claims Act violations. Since the Court concludes that the Government's evidence fails to prove False Claims Act violations on the two additional days, the Court does not need to examine the Defendants' evidence as to these days. As for the original three days, the Court is not persuaded by the Defendants' evidence that the hours on these days were improperly calculated.[3] Accordingly, the Court finds that there were 3 False Claims Act violations, for which the Defendants are liable in the amount of $ 10,000 each.

The Government insists on pursuing a case that should long have been over.[4] If the Court acceded to all of the

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[2] The Court interprets the Court of Appeals' opinion as applying only to the Court's findings on liability under the False Claims Act. Accordingly, the Court will not reconsider its determination of the unjust enrichment damages

[3] The Government claims that the Defendants should not be permitted to present any evidence because they failed to raise the issue of the Special Master's time calculations on appeal. The Court does not have to reach this issue. The Court does not find there were False Claims Act violations on the two additional days, even without consideration of the Defendant's evidence. Thus, the Defendants' evidence as to these two additional days is irrelevant. As for the initial three days, the Court finds that the Defendant's additional proof is inadequate to defend against liability on these days. Because the Court reaffirms its initial ruling as to these days, the Government is not prejudiced by the Court's consideration of Defendant's post-remand proof.

[4] Because the False Claims Act has become subject to possible overreaching, Deputy Attorney General Eric Holder issued a letter requesting U.S. Attorneys to use this statute carefully. The overzealous use of the False Claims Act has led to Congress' consideration of a bill

Government's requests, this litigation would proceed well into the next century. The Government has won its case and gained a substantial recovery. Dr. Krizek is now retired and is no longer practicing psychiatry. Although apparently a fine physician, he is now a broken man. Not only is he out of the medical profession, but also he is suffering from the advanced stages of cancer. The Government refuses to let go of this case. When it began its case, the Government was seeking over $ 80 million worth of damages, a figure that the Court of Appeals declared was "astronomical." *Krizek III*, F.3d at 940. Despite the fact that Dr. Krizek is incapable of paying such a sum, the Government continues to relentlessly pursue Dr. Krizek, who is at this point a broken and sick man. The Government's pursuit of Dr. Krizek is reminiscent of Inspector Javert's quest to capture Jean Valjean in Victor Hugo's Les Miserables. While the Government's vigor in pursuing violators of the law is to be commended, there comes a point when a civilized society must say enough is enough. That point has been reached in this case.

An appropriate Order accompanies this Memorandum Opinion.

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that would set limitations on the use of this statute. See One Man's Fraud, Wash. Post, June 7, 1998, at C6.

Date 7/14/98

Stanley Sporkin
United States District Judge

ORDER

This matter comes before the Court on remand from the Court of Appeals' decision in this case United States v. Krizek, 324 U.S. App. D.C. 175, 111 F.3d 934 (1997). For the reasons stated in the accompanying Memorandum Opinion, it is hereby

ORDERED that the Defendants are liable to the Government in the amount of $ 47,105.39 in unjust enrichment. The Defendants are also liable for 3 False Claims Act violations, for a total of $ 30,000 in [**15] liability to the Government. In light of the Court of Appeals instructions on remand, the total liability of the Defendants should be reduced from $ 157,105.39 to $ 77,105.39; it is further

ORDERED that the Defendants are also required to pay $ 11,000 for the costs of the special master.

Date 7/14/98

Stanley Sporkin
United States District Judge

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 96-5045, Consolidated with No. 96-5046

UNITED STATES OF AMERICA,
APPELLANT/CROSS-APPELLEE
v.
GEORGE O. KRIZEK, M.D., ET AL.,
APPELLEES/CROSS-APPELLANTS

December 2, 1996, Argued
May 2, 1997, Decided

PRIOR HISTORY: Appeals from the United States District Court for the District of Columbia. (No. 93cv00054).

DISPOSITION: Remanded.

COUNSEL: Mark E. Nagle, Assistant United States Attorney, argued the cause for appellant/cross-appellee, with whom Eric H. Holder, Jr., United States Attorney, R. Craig Lawrence and Bruce R. Hegyi, Assistant United States Attorneys, were on the briefs.

Paul D. Clement argued the cause for appellees/cross-appellants, with whom Christopher A. Cole and Paul T. Cappuccio were on the briefs.

JUDGES: Before: SILBERMAN, GINSBURG and SENTELLE, Circuit Judges. Opinion for the court filed by Circuit Judge SENTELLE.

OPINION BY: SENTELLE

OPINION: SENTELLE, *Circuit Judge*: This appeal arises from a civil suit brought by the government against a

psychiatrist and his wife under the civil False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3731, and under the common law. The District Court found defendants liable for knowingly submitting false claims and entered judgment against defendants for $ 168,105.39. The government appealed, and the defendants filed a cross-appeal. We hold that the District Court erred and remand for further proceedings.

I.

The government filed suit against George and Blanka Krizek for, *inter alia*, violations of the civil FCA, 31 U.S.C. §§ 3729-3731. Dr. George Krizek is a psychiatrist who practiced medicine in the District of Columbia. His wife, Blanka Krizek, worked in Dr. Krizek's practice and maintained his billing records. At issue are reimbursement forms submitted by the Krizeks to Pennsylvania Blue Shield ("PBS") in connection with Dr. Krizek's treatment of Medicare and Medicaid patients.

The government's complaint alleged that between January 1986 and March 1992 Dr. Krizek submitted 8,002 false or unlawful requests for reimbursement in an amount exceeding $ 245,392. The complaint alleged two different types of false claims: first, some of the services provided by Dr. Krizek were medically unnecessary; and second, the Krizeks "upcoded" the reimbursement requests, that is billed the government for more extensive treatments than were, in fact, rendered.

A doctor providing services to a Medicare or Medicaid recipient submits a claim for reimbursement to a Medicare carrier, in this case PBS, on a form known as the "HCFA 1500." The HCFA 1500 requires the doctor to provide his identification number, the patient's information, and a five-digit code identifying the services for which reimbursement is sought. A list of the five-digit codes is contained in the American Medical Association's Current Procedures Terminology Manual ("CPT"). For instance, the Manual notes that the CPT code "90844" is used to request reimbursement

for an individual medical psychotherapy session lasting approximately 45 to 50 minutes. The CPT code "90843" indicates individual medical psychotherapy for 20 to 30 minutes. An HCFA 1500 lists those services provided to a single patient, and may include a number of CPT codes when the patient has been treated over several days or weeks.

Before the District Court, the government argued that the amount of time specified by the CPT for each reimbursement code indicates the amount of time spent "face-to-face" with the patient. The government focused on the Krizeks' extensive use of the 90844 code. According to the government, this code should be used only when the doctor spends 45 to 50 minutes with the patient, not including time spent on the phone in consultation with other doctors or time spent discussing the patient with a nurse. The government argued that the Krizeks had used the 90844 code when they should have been billing for shorter, less-involved treatments.

Based on its claims of unnecessary treatment and upcoding the government sought an extraordinary $81 million in damages. This amount included $ 245,392 in actual damages and civil penalties of $10,000 for each of 8,002 separate CPT codes. During a three-week bench trial, the District Court determined that the case would initially be tried on the basis of seven patients which the government described as representative of the Krizeks' improper coding and treatment practices. *United States v. Krizek*, 1994 U.S. Dist. LEXIS 21095, No. 93-0054 (D.D.C. March 9, 1994) (Protective Order). The determination of liability would then "be equally applicable to all other claims." *Id.* On July 19, 1994, the District Court issued a Memorandum Opinion, *United States v. Krizek*, 859 F. Supp. 5, 8 (D.D.C. 1994) [hereinafter *Krizek I*], holding that the government had not established that the Krizeks submitted claims for unnecessary services. The Court noted that the government's witness failed to interview the patients or any doctors or nurses. *Id.* The District Court also rejected the government's theory that the Krizeks were liable for requesting reimbursement when

some of the billed time was spent out of the presence of the patient. *Id.* At 10. The Court found that it was common and proper practice among psychiatrists to bill for time spent reviewing files, speaking with consulting physicians, etc. *Id.*

Despite having rejected the government's arguments on these claims, the Court determined that the Krizeks knowingly made false claims in violation of the FCA. *Id.* at 13. The Court found that because of a "seriously deficient" system of recordkeeping the Krizeks "submitted bills for 45-50 minute psychotherapy sessions ... when Dr. Krizek could not have spent the requisite time providing services, face-to-face, or otherwise." *Id.* at 11, 12. For instance, on some occasions within the seven-patient sample, Dr. Krizek submitted claims for over 21 hours of patient treatment within a 24-hour period. *Id.* at 12. The Court stated, "While Dr. Krizek may have been a tireless worker, it is difficult for the Court to comprehend how he could have spent more than even ten hours in a single day serving patients." *Id.* The Court stated that these false statements

> were not "mistakes" nor merely negligent conduct. Under the statutory definition of "knowing" conduct the Court is compelled to conclude that the defendants acted with reckless disregard as to the truth or falsity of the submissions. As such, they will be deemed to have violated the False Claims Act.

Id. at 13-14.

Having found the Krizeks liable within the seven-patient sample, the Court attempted to craft a device for applying the determination of liability to the entire universe of claims. Here, the District Court relied on the testimony of a defense witness that he could not recall submitting more than twelve 90844 codes--nine hours worth of patient treatment--for a single day. *Id.* at 12. Based on this testimony, the District Court stated that nine hours per day was "a fair and reasonably accurate assessment of the time Dr. Krizek

actually spent providing patient services." *Id.* The Court, accordingly, determined that the Krizeks would be liable under the FCA on every day in which

> claims were submitted in excess of the equivalent of twelve (12) 90844 claims (nine patient-treatment hours) in a single day and where the defendants cannot establish that Dr. Krizek legitimately devoted the claimed amount of time to patient care on the day in question.

Id. at 14.

On April 6, 1995, the District Court, with the consent of the parties, referred the matter to a Special Master with instructions to investigate the 8,002 challenged CPT codes and, applying the nine-hour presumption, to determine 1) the single damages owed by the Krizeks; 2) the amount of the single damages trebled; 3) the number of false claims submitted by defendants; and 4) the number of false claims multiplied by $ 5000. *United States v. Krizek*, 1995 U.S. Dist. LEXIS 21531, No. 93-0054 (D.D.C. April 6, 1995) (Order of Reference). After considering evidence submitted by the parties, the Special Master determined that the defendants requested reimbursement for more than nine hours per day of patient treatment on 264 days. *United States v. Krizek, No.* 93-0054, at 15 (D.D.C. June 6, 1995) (Special Master Report). The Special Master found single damages of $47,105.39, which when trebled totaled $141,316.17. He then determined to treat each of the 1,149 false code entries as a separate claim, even where several codes were entered on the same HCFA 1500. Multiplied by $5000 per false claim, this approach produced civil penalties of $5,745,000.

After considering motions by the parties, the District Court issued a second opinion, *United States v. Krizek*, 909 F. Supp. 32 (D.D.C. 1995) [hereinafter *Krizek II*], which modified its earlier decision.

The Court stated that it accepted the Special Master's factual findings, *Id.* at 33, but was applying a different

approach in calculating damages. First, the Court awarded damages of $47,105.38 to the government for unjust enrichment based on the nine-hour presumption. *Id.* at 33. The Court then stated:

> While the Court set a nine hour benchmark to determine which claims were improper, the Court will now set an even higher benchmark for classifying claims that fall under the False Claims Act so that there can be no question as to the falsity of the claims. The Court has determined that the False Claims Act has been violated where claims have been made totaling in excess of twenty-four hours within a single twenty-four hour period and where defendants have provided no explanation for justifying claims made for services rendered virtually around the clock.

Id. at 34. Claims in excess of twenty-four hours of patient treatment per day had made eleven times in the six-year period. *Id.* The Court assessed fines of $10,000 for each of the eleven false claims, which, combined with single damages of $47,105.39, totaled $157,105.39. *Id.* The Court also assessed Special Master's fees against the Krizeks in the amount of $11,000. *Id.* The government appealed, and the Krizeks cross-appealed. We first turn to the government's appeal.

II.

The government argues that the District Court's use of a twenty-four hour presumption, having earlier announced its intent to use nine hours as the benchmark, prejudiced its prosecution of the claim. We agree and remand for further proceedings.

In *Krizek I*, the District Court found nine hours to be "a fair and reasonably accurate assessment of the time Dr. Krizek actually spent providing patient services" and held that defendants were presumptively liable for all claims in excess of nine hours per day. 859 F. Supp. at 12. Before the

Special Master, the government relied on this finding by adopting conservative assumptions that favored the Krizeks. For instance, the government assumed that a 90843 code, indicating a 20 to 30 minute psychotherapy session, would be credited as a 20 minute treatment for determining whether the Krizeks had over-billed. Likewise, the government treated 90844 claims, which indicate 45 to 50 minute sessions, as 45 minutes of patient treatment. Considering the large number of claims submitted on any given day these assumptions may have had a material effect on the damages proved up by the government. However, because the damages were likely to be substantial already, the government chose not to proffer less generous approximations. The government also relied on *Krizek I* by declining to pursue discovery concerning Dr. Krizek's private pay patients. Presumably, if the government had introduced evidence on these additional patients it could have established that the Krizeks billed in excess of twenty-four hours on more days than indicated by Medicare and Medicaid records alone.

The District Court announced its intention to abandon the nine-hour presumption in favor of a stricter benchmark only after receiving the Special Master's Report. While this higher standard may have been permissible, the District Court erred in issuing judgment based on the new presumption without permitting the parties to introduce additional evidence. We do not hold, as urged by the government, that the District Court was prohibited from revisiting its earlier finding and replacing it with the twenty-four hour presumption. We hold instead that, even assuming the District Court was free to revisit this issue, it could not properly do so without allowing the parties to introduce additional evidence.

The government also asserts that the District Court impermissibly disregarded the factual findings of the Special Master in imposing liability for only eleven false claims as opposed to 1,149. We disagree. Under FED. R. CIV. PRO. 53(e)(2) "the court shall accept the master's findings of fact unless clearly erroneous." Findings of a special master are not

to be disturbed unless the court "is left with the definite and firm conviction that a mistake has been committed." *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 123, 23 L. Ed. 2d 129, 89 S. Ct. 1562 (1969) (internal quotations omitted); *see also* 9A WRIGHT & MILLER, CIVIL PRACTICE AND PROCEDURE: CIVIL § 2614, at 699 (2nd ed. 1995). However, the Special Master's Report did not determine, as a matter of fact, that 1,149 false claims had been made. His report stated only that, applying the nine-hour presumption established by the District Court, 1,149 claims had been made in excess of the benchmark. As the Special Master stated himself, "What I did was try to identify the number of claims in excess of nine hours a day, and pursuant to the Court's earlier ruling, I called those false claims and treated them as false claims." *United States v. Krizek*, 909 F. Supp. 32, 33 (D.D.C. 1995) (Transcript of Hearing). Therefore, the District Court did not reject the factual findings of the Special Master, but only afforded to those findings a different legal consequence.

III.

The Krizeks cross-appeal on the grounds that the District Court erroneously treated each CPT code as a separate "claim" for purposes of computing civil penalties. The Krizeks assert that the claim, in this context, is the HCFA 1500 even when the form contains a number of CPT codes.

The FCA defines "claim" to include

> any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

31 U.S.C. § 3729(c). Whether a defendant has made one false claim or many is a fact-bound inquiry that focuses on the specific conduct of the defendant. *In United States v. Bornstein*, 423 U.S. 303, 307, 96 S. Ct. 523, 46 L. Ed. 2d 514 (1976),[1] for instance, the Supreme Court considered the liability of a subcontractor who delivered 21 boxes of falsely labeled electron tubes to the prime contractor in three separate shipments. The prime contractor, in turn, delivered 397 of these tubes to the government and billed the government using 35 invoices. The trial court awarded 35 statutory forfeitures against the subcontractor, one for each invoice. The Court of Appeals reversed, holding that there was only one forfeiture because there had been only one contract. The Supreme Court disagreed with both positions and held that there had been three false claims by the subcontractor, one for each shipment of falsely labeled tubes. *Id.* at 313. The Court stated, "The focus in each case [must] be upon the specific conduct of the person from whom the Government seeks to collect the statutory forfeitures." *Id.* Because the subcontractor committed three separate causative acts—dispatching each shipment of the falsely marked tubes--it would be liable for three separate forfeitures. *Id.*; *see also United States ex rel. Marcus v. Hess*, 317 U.S. 537, 552, 87 L. Ed. 443, 63 S. Ct. 379 (1943) (holding that the government was entitled to a forfeiture for each project for which a collusive bid was entered even though the bids included additional false forms); *United States v. Grannis*, 172 F.2d 507, 515 (4th Cir.) (assessing ten forfeitures against defendant for each of ten fraudulent vouchers even though the vouchers listed 130 items), *cert. denied*, 337 U.S. 918, 93 L. Ed. 1727, 69 S. Ct. 1160 (1949).

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[1] Although Bornstein applied an earlier version of the False Claims Act, the definition of "claim" applied by the Court was similar to the definition applicable here. *See Bornstein*, 423 U.S. at 309 n.4 (stating that a claim is "a demand for money or for some transfer of public property") (internal quotations omitted).

Bornstein was applied by the United States Court of Claims in *Miller v. United States*, 213 Ct. Cl. 59, 550 F.2d 17, 24 (Ct.Cl. 1977), another case considering the FCA liability of a contractor. The contractor in Miller submitted five monthly billings to the government in which eleven invoices were enclosed. The Court found that there had been five false claims, one for each occasion on which the contractor made a request for payment. 550 F.2d at 23. Similarly, in *United States v. Woodbury*, 359 F.2d 370, 378 (9th Cir. 1966), the Ninth Circuit considered what civil penalties attached to ten false applications for payment when the applications included false invoices. Again, the Court imposed ten penalties, one for each separate submission, even though the false invoices were used to calculate the amount submitted. *Id.* at 377-78.

The gravamen of these cases is that the focus is on the conduct of the defendant. The Courts asks, "With what act did the defendant submit his demand or request and how many such acts were there?" In this case, the Special Master adopted a position that is inconsistent with this approach. He stated,

> The CPT code, not the HCFA 1500 form, is the source used to permit federal authorities to verify and account for discrete units of medical service provided, billed and paid for. In sum, the government has demanded a specific accounting unit to identify and verify the services provided, payments requested and amounts paid under the Medicare/Medicaid program. The CPT code, not the HCFA 1500 form, is that basic accounting unit.

United States v. Krizek, No. 93-0054, at 21 (D.D.C. June 6, 1995) (Special Master Report). The Special Master concluded that because the government used the CPT code in processing the claims, the CPT code, and not the HCFA 1500 in its entirety, must be the claim. This conclusion, which was later adopted by the District Court, misses the point. The question turns, not on how the government chooses to process the claim, but on how many times the defendants made a "request

or demand." 31 U.S.C. § 3729(c). In this case, the Krizeks made a request or demand every time they submitted an HCFA 1500.

Our conclusion that the claim in this context is the HCFA 1500 form is supported by the structure of the form itself. The medical provider is asked to supply, along with the CPT codes, the date and place of service, a description of the procedures, a diagnosis code, and the charges. The charges are then totaled to produce one request or demandline 27 asks for total charges, line 28 for amount paid, and line 29 for balance due. The CPT codes function in this context as a type of invoice used to explain how the defendant computed his request or demand.

The government contends that fairness or uniformity concerns support treating each CPT code as a separate claim, arguing that "to count woodenly the number of HCFA 1500 forms submitted by the Krizeks would cede to medical practitioners full authority to control exposure to [FCA] simply by structuring their billings in a particular manner." Precisely so. It is conduct of the medical practitioner, not the disposition of the claims by the government, that creates FCA liability. *See Alsco-Harvard Fraud Litigation*, 523 F. Supp. 790, 811 (D.D.C. 1981) (remanding for determination whether invoices were presented for payment at one time or individually submitted as separate demands for payment). Moreover, even if we considered fairness to be a relevant consideration in statutory construction, we would note that the government's definition of claim permitted it to seek an astronomical $ 81 million worth of damages for alleged actual damages of $ 245,392. We therefore remand for recalculation of the civil penalty.

The Krizeks also challenge the District Court's definition of claim on the ground that the penalties sought in the complaint would violate the Excessive Fines Clause. U.S. CONST. amend. VIII. Because we hold that the District Court incorrectly defined claim, we do not find it necessary to reach the Krizeks' Excessive Fines argument, in keeping with the

principle that courts should avoid unnecessarily deciding constitutional questions. *See Ashwander v. TVA*, 297 U.S. 288, 345-47, 80 L. Ed. 688, 56 S. Ct. 466 (1936) (Brandeis, J., concurring).

The Krizeks also challenge the District Court's use of a seven-patient sample to determine liability. As mentioned, the District Court did not consider specific evidence as to the truth or falsity of the vast majority of the challenged claims. Instead, the District Court determined to go to trial on the issue of liability using a sample comprised of cases selected by the government. As the Court explained,

> Given the large number of claims, and the acknowledged difficulty of determining the "medical necessity" of 8,002 reimbursement claims, it was decided that this case should initially be tried on the basis of seven patients and two hundred claims that the government believed to be representative of Dr. Krizek's improper coding and treatment practices. It was agreed by the parties that a determination of liability on Dr. Krizek's coding practices would be equally applicable to all 8,002 claims in the complaint.

Krizek I, 859 F. Supp. at 7 (citation omitted). The Krizeks assert that the District Court erred in freeing the government of its burden of proving the falsity of each and every claim. According to the Krizeks, they did not agree that the sample would form the basis of determining liability for the entire universe of claims; they agreed to the seven-patient sample only as a means of testing the government's theories.

We disagree with the Krizeks' interpretation of the scope of their agreement at trial. During a Status Hearing on October 19, 1993, counsel for the Krizeks not only agreed to, but proffered, the idea of going to trial based on a representative sample. At the hearing, the Court discussed with government counsel whether the Court might make an

overall determination and then submit the case to a special master. Defense counsel stated,

> Judge, may I say that we did pick out this population or the government finally identified six people. They threw in a seventh for purposes of the summary judgment motion as their best cases. Why can't we try it on those? That is to get 8,336 separate billings for God knows how many patients over six years is—

Appendix at 140. The Court responded, "You want to try six of them, we'll try six of them." Defense counsel answered "Yes." Government counsel asked, "The seven that we've got, Your Honor?" The Court stated, "Yes, we'll try those seven." *Id.* Understanding that the parties were agreeing to go to trial based on the seven representative patients, the District Court ordered,

> Having heard argument of the parties, the Court believes that it is unnecessary at this time for the Krizeks to search for and produce all of their records. The government has identified seven patients and two hundred claims for reimbursement that the government believes are representative of the Krizeks' improper coding and treatment practices. All document production for these patients and claims has already occurred. This case will go to trial on this issue of liability using these seven patients as a representative sample. A determination of liability on the issue of improper coding would be equally applicable to all other claims. As to the allegations of performance of unnecessary services, it may be that further discovery will have to take place to establish liability for the other patients and claims alleged by the government.

United States v. Krizek, 1994 U.S. Dist. LEXIS 21095, No. 93-0054, at 2 (D.D.C. March 9, 1994) (Protective Order).

This order met with no contemporaneous objection by the Krizeks. We conclude, therefore, that the Krizeks are bound by their agreement at trial that liability would be based on the seven-patient sample with damages to be extrapolated later.

Having determined that liability was properly determined by the seven-patient sample, we turn now to the question whether, in considering the sample, the District Court applied the appropriate level of scienter. The FCA imposes liability on an individual who "knowingly presents" a "false or fraudulent claim." 31 U.S.C. § 3729(a). A person acts "knowingly" if he:

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(b). The Krizeks assert that the District Court impermissibly applied the FCA by permitting an aggravated form of gross negligence, "gross negligence-plus," to satisfy the Act's scienter requirement.

In *Saba v. Compagnie Nationale Air France*, 316 U.S. App. D.C. 303, 78 F.3d 664 (D.C. Cir. 1996), we considered whether reckless disregard was the equivalent of willful misconduct for purposes of the Warsaw Convention. We noted that reckless disregard lies on a continuum between gross negligence and intentional harm. 78 F.3d at 668. In some cases, recklessness serves as a proxy for forbidden intent. *Id.* (*citing SEC v. Steadman*, 296 U.S. App. D.C. 269, 967 F.2d 636, 641 (D.C. Cir. 1992)). Such cases require a showing that the defendant engaged in an act known to cause or likely to cause the injury. 967 F.2d at 669. Use of reckless disregard as a substitute for the forbidden intent prevents the defendant from "deliberately blinding himself to the consequences of his tortious action." *Id.* at 668. In another

category of cases, we noted, reckless disregard is "simply a linear extension of gross negligence, a palpable failure to meet the appropriate standard of care." *Id.* In Saba, we determined that in the context of the Warsaw Convention, a showing of willful misconduct might be made by establishing reckless disregard such that the subjective intent of the defendant could be inferred. *Id.* at 669.

The question, therefore, is whether "reckless disregard" in this context is properly equated with willful misconduct or with aggravated gross negligence. In determining that gross negligence-plus was sufficient, the District Court cited legislative history equating reckless disregard with gross negligence. A sponsor of the 1986 amendments to the FCA stated,

> Subsection 3 of Section 3729(c) uses the term "reckless disregard of the truth or falsity of the information" which is no different than and has the same meaning as a gross negligence standard that has been applied in other cases. While the Act was not intended to apply to mere negligence, it is intended to apply in situations that could be considered gross negligence where the submitted claims to the Government are prepared in such a sloppy or unsupervised fashion that resulted in overcharges to the Government. The Act is also intended not to permit artful defense counsel to require some form of intent as an essential ingredient of proof. This section is intended to reach the "ostrich-with-his-head-in-the-sand" problem where government contractors hide behind the fact they were not personally aware that such overcharges may have occurred. This is not a new standard but clarifies what has always been the standard of knowledge required.

132 Cong. Rec. H9382-03 (daily ed. Oct. 7, 1986) (statement of Rep. Berman). While we are not inclined to view isolated statements in the legislative history as dispositive, we agree

with the thrust of this statement that the best reading of the Act defines reckless disregard as an extension of gross negligence. Section 3729(b)(2) of the Act provides liability for false statements made with deliberate ignorance. If the reckless disregard standard of section 3729(b)(3) served merely as a substitute for willful misconduct--to prevent the defendant from "deliberately blinding himself to the consequences of his tortious action"--section (b)(3) would be redundant since section (b)(2) already covers such struthious conduct. *See Kungys v. United States*, 485 U.S. 759, 778, 99 L. Ed. 2d 839, 108 S. Ct. 1537 (1988) (citing the "cardinal rule of statutory interpretation that no provision should be construed to be entirely redundant"). Moreover, as the statute explicitly states that specific intent is not required, it is logical to conclude that reckless disregard in this context is not a "lesser form of intent," *see Steadman*, 967 F.2d at 641-42, but an extreme version of ordinary negligence.

We are unpersuaded by the Krizeks' citation to the rule of lenity to support their reading of the Act. Even assuming that the FCA is penal, the rule of lenity is invoked only when the statutory language is ambiguous. *Deal v. United States*, 508 U.S. 129, 135, 124 L. Ed. 2d 44, 113 S. Ct. 1993 (1993). Because we find no ambiguity in the statute's scienter requirement, we hold that the rule of lenity is inapplicable.

We are also unpersuaded by the Krizeks' argument that their conduct did not rise to the level of reckless disregard. The District Court cited a number of factors supporting its conclusion: Mrs. Krizek completed the submissions with little or no factual basis; she made no effort to establish how much time Dr. Krizek spent with any particular patient; and Dr. Krizek "failed utterly" to review bills submitted on his behalf. *Krizek I*, 859 F. Supp. at 13. Most tellingly, there were a number of days within the seven-patient sample when even the shoddiest recordkeeping would have revealed that false submissions were being made--those days on which the Krizeks' billing approached twenty-four hours in a single day. On August 31, 1985, for instance, the Krizeks requested

reimbursement for patient treatment using the 90844 code thirty times and the 90843 code once, indicating patient treatment of over 22 hours. *Id.*at 12. Outside the seven-patient sample the Krizeks billed for more than twenty-four hours in a single day on three separate occasions. *Krizek II*, 909 F. Supp. at 34. These factors amply support the District Court's determination that the Krizeks acted with reckless disregard.

Finally, we note that Dr. Krizek is no less liable than his wife for these false submissions. As noted, an FCA violation may be established without reference to the subjective intent of the defendant. Dr. Krizek delegated to his wife authority to submit claims on his behalf. In failing "utterly" to review the false submissions, he acted with reckless disregard.

We turn finally to the Krizeks' claim that the Special Master's fees should be reduced because he "wasted considerable time by utterly failing to adhere to the intent and purpose of the Order of Reference and engaging in activities outside the scope of the reference." Brief for Appellees/Cross-Appellants at 28. We fail to see how the Special Master's time was wasted.

The jurisdiction of a Special Master is dependent on the order of reference. See FED. R. CIV. PRO. 53(C). In this case, the Order of Reference directed the Special Master to calculate the number of false claims within the parameters established in *Krizek I. United States v. Krizek*, 1995 U.S. Dist. LEXIS 21531, No. 93-0054 (D.D.C. April 6, 1995) (Order of Reference). *Krizek I* stated that the Court "will hold the defendants liable under the False Claims Act on those days where claims were submitted in excess of the equivalent of twelve (12) 90844 claims (nine patient-treatment hours) in a single day and where the defendants cannot establish that Dr. Krizek legitimately devoted the claimed amount of time to patient care on the day in question." 859 F. Supp. at 14. The Krizeks argue that the Special Master wasted time considering rebuttal evidence he would eventually reject as "beyond his jurisdiction." The evidence the Special Master wasted time considering, according to the Krizeks, was evidence they,

themselves, proferred. Before the Special Master, the Krizeks did not present specific proof that Dr. Krizek had, in fact, provided the claimed amount of patient-treatment time. The only rebuttal evidence they provided attacked the merits of the nine-hour presumption. In response, the Special Master correctly determined that he lacked authority to reconsider the District Court's opinion. We reject the Krizeks' contention that a litigant should not be billed for time spent considering irrelevant evidence when the evidence was presented by the complaining party.

The Krizeks also argue that the Special Master wasted time researching the definition of the term "claim." We do not understand how the Special Master could have determined the number of false claims, as directed, without researching the question of what constitutes a "claim."

Finally, the Krizeks object that some of the Special Master's functions were referred to a paralegal. However, the Order of Reference specifically instructed the Special Master to delegate tasks to legal assistants where "efficient and economical." As a result, we affirm the award of fees to the Special Master.

IV.

We, therefore, conclude that the District Court erred in replacing the nine-hour presumption with a twenty-four hour benchmark without providing an opportunity for the litigants to present additional evidence. We also hold that the "claim" in this context is the HCFA 1500 form. We hold that cross-appellants are bound by their stipulation that liability would be determined by the seven-patient sample. In considering this sample the District Court properly interpreted "reckless disregard" to be a linear extension of gross negligence, or "gross negligence-plus." Finally, we affirm the award of fees to the Special Master. We remand to the District Court for further proceedings consistent with this opinion.

So ordered.

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 93-0054

UNITED STATES,

Plaintiff,

v.

GEORGE O. KRIZEK, BLANKA KRIZEK,

Defendants.

December 15, 1995, DATE
December 18, 1995, FILED

COUNSEL: For UNITED STATES OF AMERICA, plaintiff: Bruce R. Hegyi, U.S. ATTORNEY'S OFFICE, Washington, DC.

For GEORGE O. KRIZEK, M.D., BLANKA H. KRIZEK, defendants: Joseph Nathan Onek, Paula Joanne Desio, CROWELL & MORING, Washington, DC. Monika Blanche Krizek, Washington, DC.

For THE WASHINGTON PSYCHIATRIC SOCIETY, a District Branch of the American Psychiatric Association, Inc., intervenor: Armin Ulrich Kuder, KUDER, SMOLLAR & FRIEDMAN, P.C., Washington, DC.

JUDGES: Stanley Sporkin, United States District Court

OPINION BY: Stanley Sporkin

MEMORANDUM OPINION

The United States filed suit against George O. Krizek, M.D. and his wife Blanka H. Krizek, alleging that they had violated the False Claims Act, 31 U.S.C. § 3729, by submitting false and inflated claims for reimbursement for psychiatric services allegedly provided to Medicaid/Medicare patients. Following a three week bench trial, this Court issued a Memorandum Opinion and Order on July 19, 1994. *United States v. Krizek*, 859 Supp. 5 (D.D.C. 1994). The Court ruled that the defendants had submitted false claims and had violated the False Claims Act. *Id.* At 13-14.

In its opinion, the Court sought to set a benchmark whereby all claims below the benchmark would be presumed valid, and all claims above the benchmark would be presumed invalid. *United States v. Krizek, 859 F. Supp. at 12.* During the trial the defendants called Dr. Norman Wilson as an expert witness. Dr. Wilson testified during cross examination that he, a hardworking psychiatrist himself, had never submitted more than nine hours worth of claims to Medicaid/Medicare in a single twenty four hour period. *Id.* The Court established the nine hour figure as the benchmark and the plaintiff and the defendants agreed to the nine hour period in post-trial memoranda. *Id.*[2] The Court ruled that all claims in excess of nine hours on a single day would be presumed invalid unless the defendants were able to produce evidence that specific claims were valid. *Id.* On the recommendation of the parties, the Court referred the matter to Special Master William H. Briggs Jr., see April 6 Order at 1-2. Among other things, the Special Master was to examine the claims submitted on days where the defendants submitted more than nine hours worth of claims for reimbursement. *Id.* at 3. The Special Master determined that there were 264 such days. See Special Master Report at 15. For those days he produced charts that showed the number of claims submitted

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[2] See Government's Proposed Memorandum and Opinion at 11; Defendant's Post-Trial Memorandum at 16.

by the defendants in excess of nine hours, in excess of twelve hours, and in excess of fifteen hours.[3] *Id.* at Appendixes B, C, and D. Additionally, the Special Master calculated the amounts that were paid to the defendants for services claims on the 264 days. *Id.* The defendants were unable to produce evidence to show that services were actually performed as they claimed.

The Special Master has made all the necessary findings. In his report the Special Master outlined the methods and formulas he used to arrive at his total. The Special Master report was comprehensive and unquestionably fair to both the plaintiff and defendant. The Court accepts the Special Master's factual findings.

The liability of the defendants is comprised of two parts. First, the defendants will have to return all that was paid to them for which invalid claims were submitted. Since all claims in excess of nine hours on a single day are presumed improper, the defendants will required to reimburse the Government for all such claims. The Special Master determined that on the 264 days where the defendants billed in excess of nine hours, the defendants submitted a total of 1,149 claims for which they were paid $ 47,105.39. *Id.* at Appendix B. The defendants must return this sum to the Government.

The defendants will also be held liable under the False Claims Act. The Act requires that the defendants be held liable for triple the amount unjustly paid to them and fined between $ 5,000 and $ 10,000 for each claim covered by the False Claim Act 31 U.S.C. § 3729(a). The False Claims Act is violated where one "knowingly" submits a false claim to the government (b). The Act further clarifies that a defendant may be deemed to have "knowingly" violated the Act if he or

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[3] The charts were organized in such a fashion that one could use the charts to easily calculate the number of claims in excess of any other hour benchmark.

she acted with a "reckless disregard as to the truth or falsity of the information." *Id.* As the Court noted in its original opinion, the False Claims Act was specifically amended in 1986 to include this new definition so that the Government might have recourse against the individual who over-bills the Government in a reckless manner *United States v. Krizek*, 859 F. Supp. At 13.

While the Court set a nine hour benchmark to determine which claims were improper, the Court will now set even a higher benchmark for classifying claims that fall under the False Claims Act so that there can be no question as to the falsity of the claims. The Court has determined that the False Claims Act has been violated where claims have been made totaling in excess of twenty four hours within a single twenty forty hour period and where defendants have provided no explanation for justifying claims made for services rendered virtually around the clock. To submit claims without proper justification in excess of twenty four hours in a single day is to act clearly with the degree of recklessness required by the Act.

The Special Master found that on a total of three days the defendants billed in excess of twenty four hours.[4] Indeed, on those days the defendants submitted eleven claims in excess of the twenty four hour benchmark. The eleven claims multiplied by $ 10,000 result in further fines of $ 110,000. In sum, the defendants' liability totals $ 157,105.39.

Defendant shall pay such sum to the Government within 60 days from the issuance of this Opinion or at such other time as the Court shall direct.

Finally, the Defendants must pay $ 11,000 owed to the Special Master for services performed in this case. Defendants will be ordered to pay the Special Master $ 2,000 a month for five months and $ 1,000 on month six.

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[4] January 6, 1987, July 7, 1987, and August 10, 1987

DATE: December 15, 1995

Stanley Sporkin
United States District Court

ORDER

For the reasons set forth in its Memorandum Opinion of this date, the Court hereby

ORDERS that Defendants pay the sum of $157,105.39 consisting of $ 47,105.39 in restitution and $ 110,000 in fines imposed pursuant to the False Claims Act. Such payment is to be made to the United States Government within 60 days, or at such other time as the Court shall direct. It is further

ORDERED that within six months of the date of this Order, Defendants shall pay the Special Master the sum of $ 11,000 for their fair share of the work performed in this matter. Such sum is to be paid in monthly installments of $ 2,000 for five months, with a final payment of $ 1,000 to be payed in the sixth month.

This Court retains jurisdiction to issue such future orders as may be required.

DATE: 12/15/95

Stanely Sporkin
United States District Court

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

United States of America,

Plaintiff,

v.

George E. Krizek and Blanka H. Krizek,

Defendants.

Civil Action No. 93-54

July 18, 1994, Decided
July 19, 1994, Filed

COUNSEL: For Plaintiff(s): Bruce R. Hegyi, Washington, DC. John Robert Munich, Jefferson City, MO.

For Defendants: Brian William Shaughnessy, SHAUGHNESSY, BOROWSKI & GAGNER, Washington, DC. Joseph Nathan Onek, Michael Eberhardt, CROWELL & MORING, Washington, DC. Marsha Ellen Swiss, Washington, DC. Monika Blanche Krizek, Washington, DC.

JUDGES: Sporkin
OPINION BY: STANLEY SPORKIN

MEMORANDUM OPINION AND ORDER

On January 11, 1993, the United States filed this civil suit against George O. Krizek, M.D. and Blanka H. Krizek under the False Claims Act, 31 U.S.C. §§ 3729-3731, and at common law. The government brought the action against the Krizeks' alleging false billing for Medicare and Medicaid patients. The five counts include claims for (1) "Knowingly Presenting a False or Fraudulent Claim", 31 U.S.C. §

3729(a)(1); (2) "Knowingly Presenting a False or Fraudulent Record", 31 U.S.C. § 3729(a)(2); (3) "Conspiracy to Defraud the Government"; (4) "Payment under Mistake of Fact"; and (5) "Unjust Enrichment". In its claim for relief, the government asks for triple the alleged actual damages of $ 245,392 and civil penalties of $ 10,000 for each of the 8,002 allegedly false reimbursement claims pursuant to 31 U.S.C. § 3729.

The government alleges two types of misconduct related to the submission of bills to Medicare and Medicaid. The first category of misconduct relates to the use of billing codes found in the American Medical Association's "Current Procedural Terminology" ("CPT"), a manual that lists terms and codes for reporting procedures performed by physicians. The government alleges that Dr. Krizek "up-coded" the bills for a large percentage of his patients by submitting bills coded for a service with a higher level of reimbursement than that which Dr. Krizek provided. As a second type of misconduct, the government alleges Dr. Krizek "performed services that should not have been performed at all in that they were not medically necessary." Original Complaint P 24.

Given the large number of claims, and the acknowledged difficulty of determining the "medical necessity" of 8,002 reimbursement claims, it was decided that this case should initially be tried on the basis of seven patients and two hundred claims that the government believed to be representative of the Dr. Krizek's improper coding and treatment practices. See Order of March 9, 1994. It was agreed by the parties that a determination of liability on Dr. Krizek's coding practices would be equally applicable to all 8,002 claims in the complaint. A three week bench trial ensued.

Findings of Fact

Dr. Krizek is a psychiatrist. Dr. Krizek's wife, Blanka Krizek was responsible for overseeing Dr. Krizek's billing operation for a part of the period in question. Dr. Krizek's

Washington, D.C. psychiatric practice consists in large part in the treatment of Medicare and Medicaid patients. Much of Doctor Krizek's work involves the provision of psychotherapy and other psychiatric care to patients at the Washington Hospital Center.

Under the Medicare and Medicaid systems, claims for reimbursement are submitted on documents known as Health Care Financing Administration ("HCFA") 1500 Forms. These forms are supposed to contain the patient's identifying information, the provider's Medicaid or Medicare identification number, and a description of the provided procedures for which reimbursement is sought. These procedures are identified by a standard, uniform code number as set out in the American Medical Association's "Current Procedural Terminology" ("CPT") manual, a book that lists the terms and codes for reporting procedures performed by physicians.

Dr. Krizek was a voluntary "participating provider" in the Medicare and Medicaid programs. As a participating provider, Dr. Krizek was required to follow the billings and documentation requirements of Medicare/Medicaid and Pennsylvania Blue Shield ("PBS"), the Medicare carrier for the greater Washington, D.C. area. Providers were informed of Medicare/Medicaid rules and directions through the CPT manual and the Medicare Reports and Medicare Bulletins.

The Medicare reports that Dr. Krizek received indicated that he was to maintain documentation for each claim he submitted to Medicare. These reports noted that hospital progress notes and patient office records must verify that a service 1) actually was provided, 2) was performed at the level reported, and 3) was medically necessary. The Medicare Reports stated that refunds would be requested for any payments made by Blue Shield not supported by hospital records. See Gov. Exh. 6 & 7.

The CPT manuals contained billing numbers to be used by providers when submitting claims to Medicare/Medicaid for

reimbursement. The claim number submitted by or on behalf of the provider describes by code the service rendered and constitutes the provider's claim for such service. The submission of a claim on the HCFA 1500 form is a certification by the provider to the government of the correctness of the information submitted and, among other things, that the services were performed by the provider, and that the provider will maintain "such records as are necessary to disclose fully the extent of the services provided. . . ." See Government Exh. 5

The government in its complaint alleges both improper billing for services provided and the provision of medically unnecessary services. The latter of these two claims will be addressed first.

Medical Necessity

The record discloses that Dr. Krizek is a capable and competent physician. Dr. Krizek was originally trained in Prague, in what was then Czechoslovakia, at the Charles University School of Medicine. Dr. Krizek also received a medical degree from Rudolf's University, in Vienna, Austria. Dr. Krizek came to the United States in 1968, where he did a residency at Beth Israel Hospital in New York City. He arrived in the Washington, D.C. area in the early 1970's where he has been engaged in the practice of psychiatry for approximately 21 years. The trial testimony of Dr. Krizek, his colleagues at the Washington Hospital Center, as well as the testimony of a former patient, established that Dr. Krizek was providing valuable medical and psychiatric care during the period covered by the complaint. The testimony was undisputed that Dr. Krizek worked long hours on behalf of his patients, most of whom were elderly and poor.

Many of Dr. Krizek's patients were afflicted with horribly severe psychiatric disorders and often suffered simultaneously from other serious medical conditions. For example, one of the seven representative patients had paranoid psychosis and organic brain dementia, coupled with a series of other medical problems including colon cancer, diabetes, herpes, and viral

encephalitis. Another patient suffered from chronic depression and had accompanying delusions. A third had a history of repeated psychiatric hospitalizations, was in an acute schizophrenic state, and also suffered from epilepsy. A fourth patient suffered from suicidal and assaultive behavior, hallucinations, paralysis of the left-side of the body, and was an intravenous cocaine and heroin user.

The government takes issue with Dr. Krizek's method of treatment of his patients, arguing that some patients should have been discharged from the hospital sooner, and that others suffered from conditions which could not be ameliorated through psychotherapy sessions, or that the length of the psychotherapy sessions should have been abbreviated. The government's expert witness's opinions on this subject came from a cold review of Dr. Krizek's notes for each patient. The government witness did not examine or interview any of the patients, or speak with any other doctors or nurses who had actually served these patients to learn whether the course of treatment prescribed by Dr. Krizek exceeded that which was medically necessary.

Dr. Krizek testified credibly and persuasively as to the basis for the course of treatment for each of the representative patients. The medical necessity of treating Dr. Krizek's patients through psychotherapy and hospitalization was confirmed via the testimony of other defense witnesses. The Court credits Dr. Krizek's testimony on this question as well as his interpretation of his own notes regarding the seriousness of each patients' condition and the medical necessity for the procedures and length of hospital stay required. The Court finds that the government was unable to prove that Dr. Krizek rendered services that were medically unnecessary.

Improper Billing

On the question of improper billing or "up-coding", the government contends that for approximately 24 percent of the bills submitted, Dr. Krizek used the CPT Code for a 45-50

minute psychotherapy session (CPT Code 90844) when he should have billed for a 20-30 minute session (CPT Code 90843). The government also contends that for at least 33 percent of his patients, Dr. Krizek billed for a full 45-50 minute psychotherapy session, again by using CPT code 90844, when he should have billed for a "minimal psychotherapy" session (CPT 90862). These two latter procedures are reimbursed at a lower level than 90844, the 45-50 minute psychotherapy session, which the government has referred to as "the Cadillac" of psychiatric reimbursement codes.

The primary thrust of the government's case revolves around the question whether Dr. Krizek's use of the 90844 CPT code was appropriate. For the most part, the government does not allege that Dr. Krizek did not see the patients for whom he submitted bills. Instead, the government posits that the services provided during his visits either did not fall within the accepted definition of "individual medical psychotherapy" or, if the services provided did fit within this definition, the reimbursable service provided was not as extensive as that which was billed for. In sum, the government claims that whenever Dr. Krizek would see a patient, regardless of whether he simply checked a chart, spoke with nurses, or merely prescribed additional medication, his wife or his employee, a Mrs. Anderson, would, on the vast majority of occasions, submit a bill for CPT code 90844--45-50 minutes of individual psychotherapy.

In presenting its case that Dr. Krizek did not provide the billed-for services as required by the CPT, the government contends that the definition of the 90844 code requires 45-50 minutes of "face-to-face" contact with the patient. By example, if a doctor were to spend 10 minutes reviewing a patient's file and talking to nurses about the patient's condition, then spend 20 minutes in a face-to-face psychiatry session with the patient, and finally take an additional fifteen minutes after the session to consult with the patient's spouse or prescribe medication, this would, according to the

government, count only as a 20-30 minute individual psychotherapy session, to be billed as code 90843. Under the government's interpretation of the code, even if as much as an hour of a physician's time is devoted to a patient's case, with half that time spent in a face-to-face psychotherapy session and the rest spent on related services, the doctor is only permitted reimbursement under the 90800 series of codes for the 30 minutes spent face-to-face. The 90800 series of codes is described as follows in the documents sent by PBS to the Krizeks during the relevant time period:

Code	Description of Services
90841	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; time unspecified.
90843	Approximately 20 to 30 minutes.
90844	Approximately 45 to 50 minutes.

The government's witnesses[1] testified that as initially conceived, the definition of the CPT codes is to incorporate the extra time spent in its level of reimbursement. It was expected by the authors of the codes that for a 45-50 minute 90844 session a doctor would spend additional time away from the patient reviewing or dictating records, speaking with nurses, or prescribing medication. The government's

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[1] One of whom was Barton C. McCann, M.D., M.P.H., formerly Chief Medical Officer of the National Health Service Corps, and formerly Chief of the Special Coverage Issues Branch of the Office of Coverage Policy of the Health Coverage Financing Administration. Dr. McCann has been a member of the CPT Editorial Panel of the American Medical Association.

witnesses testified that the reimbursement rate for 90844 took into account the fact that on a 45-50 minute session the doctor would likely spend twenty additional minutes away from the patient. As such, the doctor is limited to billing for time actually spent "face-to-face" with the patient.

Dr. and Mrs. Krizek freely admit that when a 90844 code bill was submitted on the doctor's behalf, it did not always reflect 45-50 minutes of face-to-face psychotherapy with the patient. Instead, the 45-50 minutes billed captured generally the total amount of time spent on the patient's case, including the "face-to-face" psychotherapy session, discussions with medical staff about the patient's treatment/progress, medication management, and other related services. Dr. Krizek referred to this as "bundling" of services, all of which, Dr. and Mrs. Krizek testified, they reasonably believed were reimbursable under the 90844 "individual medical psychotherapy" code.

Defendant's witnesses testified that it was a common and proper practice among psychiatrists nationally, and in the Washington, D.C. area, to "bundle" a variety of services, including prescription management, review of the patient file, consultations with nurses or the patients' relatives into a bill for individual psychotherapy, whether or not these services took place literally in view of the patient. Under the defense theory, if a doctor spent 20 minutes in a session with a patient and ten minutes before that in a different room discussing the patient's symptoms with a nurse, and fifteen minutes afterwards outlining a course of treatment to the medical staff, it would be entirely appropriate, under their reading and interpretation of the CPT, to bill the 45 minutes spent on that patients' care by using CPT code 90844.

The testimony of the defense witnesses on this point was credible and persuasive. These witnesses included Dr. Chester Schmidt, Associate Dean of Johns Hopkins Medical School who serves on the editorial panel of the CPT and on the American Psychiatric Association Committee on Codes and Reimbursement, Dr. Tracy Gordy, former President of the

Texas Psychiatric Association who also serves on the CPT editorial panel and the APA committee, and four psychiatric professionals who worked with Dr. Krizek as a member of the medical staff at the Washington Hospital Center. The CPT codes which the government insists require face-to-face rendition of services never used the term "face-to-face" in its code description during the time period covered by this litigation.[2] The relevant language describing the code is ambiguous.

The Court finds that the government's position on this issue is not rational and has been applied in an unfair manner to the medical community, which for the most part is made up of honorable and dedicated professionals. One government witness testified that a 15 minute telephone call made to a consulting physician in the patient's presence would be reimbursable, while if the doctor needed to go outside the patient's room to use the telephone--in order to make the same telephone call--the time would not be reimbursable. In addition, the government witnesses testified that if a doctor should happen to spend 25 minutes with a patient in psychotherapy, and 20 minutes working away from the patient on other matters for the patient, then the doctor should bill for a 20 minute 90843 session, and should submit a second claim for the non-face-to-face time (using, for example, the 90862 code-pharmacological management). The government's witnesses admitted that submitting two bills in this way would result in payment for only one submission, as the relevant government reimbursement practice only permits reimbursement for one procedure at a given time. Dual billing, despite the lack of payment, is nevertheless required

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[2] The scope of this lawsuit covers bills submitted by the Krizeks between January 1986 and March 1992. In 1992, the CPT code book was revised to introduce "evaluation and management codes" to cover non-procedure, non-surgical oriented services. Only since the introduction of the evaluation and management codes has the term "face-to-face" appeared in the guidelines section of the CPT.

under the government witnesses' interpretation of the relevant rules.

The Court will not impose False Claims Act liability based on such a strained interpretation of the CPT codes. The government's theory of liability is plainly unfair and unjustified. Medical doctors should be appropriately reimbursed for services legitimately provided. They should be given clear guidance as to what services are reimbursable. The system should be fair. The system cannot be so arbitrary, so perverse, as to subject a doctor whose annual income during the relevant period averaged between $ 100,000 and $ 120,000 dollars, to potential liability in excess of 80 million dollars[3] because telephone calls were made in one room rather than another.

The Court finds that Doctor Krizek did not submit false claims when he submitted a bill under CPT Code 90844 after spending 45-50 minutes working on a patient's case, even though not all of that time was spent in direct face-to-face contact with the patient. Even Dr. Reznik, PBS's reviewer and the government's expert psychiatric witness acknowledged that Dr. Krizek provided important services during non-face-to-face time:

> Now certainly, in both inpatient and outpatient practices, one does other things for the patient. That's good medical care, and its appropriate. And

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[3] The government alleges in the complaint that overbills amounted to $ 245,392 during the six-year period covered by the lawsuit. Trebling this damage amount, and adding the $ 10,000 statutory maximum penalty requested by the government for each of the 8,002 alleged false claims, results in a total potential liability under the complaint of more than $80,750,000. Dr. Krizek is not public enemy number one. He is at worst, a psychiatrist with a small practice who keeps poor records. For the government to sue for more than eighty million dollars in damages against an elderly doctor and his wife is unseemly and not justified. During this period, a psychiatrist in most instances would be reimbursed between $ 48 and $ 60 for a 45-50 minute session and $ 40 or less for a 20-30 minute session. This is hardly enough for any professional to get rich.

> what Dr. Krizek indicated in some of his statements that he did, are certainly appropriate and proper care. But it is not appropriate to include those in individual medical psychotherapy.

Reznik Testimony, Vol. III at 21. The Court finds that the defendants' "bundled" services interpretation of the CPT code 90844 is not inconsistent with the plain, common-sense reading of the "description of services" listed by Pennsylvania Blue Shield in its published Procedure Terminology Manual.

BILLING IRREGULARITIES

While Dr. Krizek was a dedicated and competent doctor and cannot be faulted for his interpretation of the 90844 code, his billing practices, or at a minimum his oversight of his wife's and Mrs. Anderson's billing system, was seriously deficient. Dr. Krizek knew little or nothing of the details of how the bills were submitted by his wife and Mrs. Anderson. Mrs. Krizek was responsible for submitting to Medicare/Medicaid claims for reimbursement for the patients who were admitted to Dr. Krizek's service at the Washington Hospital Center and for those few Medicare/Medicaid outpatients Dr. Krizek saw in his home. Mrs. Anderson was responsible for submitting bills when Dr. Krizek saw as "consults" Medicare/Medicaid patients who were admitted to another physician's service at Washington Hospital Center, and when Dr. Krizek was "covering" for other physicians.

The basic method of billing by Mrs. Krizek and Mrs. Anderson was to determine which patients Dr. Krizek had seen, and then to assume what had taken place was a 50-minute psychotherapy session, unless told specifically by Dr. Krizek that the visit was for a shorter duration. Mrs. Krizek frequently made this assumption without any input from her husband. Mrs. Krizek acknowledged at trial that she never made any specific effort to determine exactly how much time was spent with each patient. Mrs. Krizek felt it was fair and appropriate to use the 90844 code as a rough approximation of the time spent, because on some days, an examination

would last up to two hours and Mrs. Krizek would still bill 90844.

Mrs. Anderson also would prepare and submit claims to Medicare/Medicaid with no input from Dr. Krizek. Routinely, Mrs. Anderson would simply contact the hospital to determine what patients were admitted to various psychiatrists services, and would then prepare and submit claims to Medicare/Medicaid without communicating with Dr. or Mrs. Krizek about the claims she was submitting and certifying on Dr. Krizek's behalf. At the most, Mrs. Anderson would occasionally call Dr. Krizek and ask if his service for a particular patient was for a "short session." Dr. Krizek would tell Mrs. Anderson "yes" or "no." For those "short sessions," Mrs. Anderson would submit a bill for 90843--a 20-30 minute psychotherapy session. With few exceptions, Mrs. Anderson submitted 90844 claims to Medicare/Medicaid for Dr. Krizek's services. Because of the lack of communication among Dr. Krizek, Mrs. Krizek and Mrs. Anderson, and the absence of any centralized, controlled billing system, on several occasions duplicate bills were submitted by Mrs. Krizek and Mrs. Anderson on Dr. Krizek's behalf.

The net result of this system, or more accurately "non-system," of billing was that on a number of occasions, Mrs. Krizek and Mrs. Anderson submitted bills for 45-50 minute psychotherapy sessions on Dr. Krizek's behalf when Dr. Krizek could not have spent the requisite time providing services, face-to-face, or otherwise. For example, on March 9, 1985 Dr. Krizek submitted to Medicare and Medicaid 23 claims for 90844 (45-50 minutes of individual medical psychotherapy) and 5 claims for 90843 (25-30 minutes of individual medical psychotherapy). These 29 claims totaled 21.5 hours of services provided during one 24 hour period. In August 31, 1985, thirty 90844's and one 90843 were submitted.[4] At minimum, this is the equivalent of 23

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[4] The scope of this lawsuit covers the period between January 1, 1986 and March 31, 1992. Because the Krizek's billing practices remained unchanged both prior to and during the time period covered by this

hours in patient services in a 24 hour period. While Dr. Krizek may have been a tireless worker, it is difficult for the Court to comprehend how he could have spent more than even ten hours in a single day serving patients. By comparison, defense witness Dr. Norman Wilson, former head of the Department of Psychiatry at the Washington Hospital Center, testified that while he often worked 70-hour weeks on the care and treatment of his own patients, he could not recall ever submitting more than twelve 90844 claims for reimbursement in a single day. Wilson Testimony, Vol. VI at 163-64. The defendants do not deny that these unsubstantiated reimbursement claims occurred or that billing practices which led to such inaccurate billings continued through March of 1992.

While the Court does not find that Dr. Krizek submitted bills for patients he did not see, the Court does find that because of Mrs. Krizek's and Mrs. Anderson's presumption that whenever Dr. Krizek saw a patient he worked at least 45 minutes on the matter, bills were improperly submitted for time that was not spent providing patient services. Again, the defendants admit this occurred. See Defendant's Post-trial Memorandum at 11-12.

At the conclusion of the trial, both parties agreed that an appropriate bench-mark for excessive billing would be the equivalent of twelve 90844 submissions (or nine patient-service hours) in a single service day. See Defendant's Post-trial Memorandum at 16; Government's Proposed Memorandum and Opinion at 11. Considering the difficulty of reviewing all Dr. Krizek's patient records over a seven-year period, Dr. Wilson's testimony as to having submitted as many as twelve 90844 submissions in a single day, and giving full credence to unrefuted testimony that Dr. Krizek worked very long hours, the Court believes this to be a fair and reasonably accurate assessment of the time Dr. Krizek actually spent providing patient services. *See Bigelow v. RKO*

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lawsuit, the Court admitted into evidence bills submitted in 1985 as probative of the Krizek's billing practices during the period of the lawsuit.

Radio Pictures, Inc., 327 U.S. 251, 264, 90 L Ed. 652, 66 S. Ct. 574 (1946) (permitting factfinder to rake "just and reasonable estimate of damage based on relevant data" where more precise computation is not possible). Dr. and Mrs. Krizek will therefore be presumed liable for bills submitted in excess of the equivalent of twelve 90844 submissions in a single day.

NATURE OF LIABILITY

While the parties have agreed as to the presumptive number of excess submissions for which Dr. and Mrs. Krizek may be found liable, they do not agree on the character of the liability. The government submits that the Krizeks should be held liable under the False claims Act, 31 U.S.C. § 3729, *et seq*. By contrast, defendants posit that while the United States may be entitled to reimbursement for any unjust enrichment attributable to the excess billings, the Krizeks' conduct with regard to submission of excess bills to Medicare/Medicaid was at most negligent, and not "knowing" within the definition of the statute. In their defense, defendants emphasize the "Ma and Pa" nature of Dr. Krizek's medical practice, the fact that Mrs. Krizek did attend some Medicare billing seminars in an effort to educate herself, and the fact that Mrs. Krizek consulted hospital records and relied on information provided by her husband in preparing bills.

By its terms, the False Claims Act provides, inter alia, that: Any person who--

> (1) knowingly presents, or causes to be presented, to [the Government] . . . a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

is liable to the United States Government for a civil penalty of not less than $ 5,000.00 and not more than $ 10,000.00, plus three times the amount of damages which the Government sustains because of the act of that person. . . .31 U.S.C. 3729 (a). The mental state required to find liability under the False Claims Act is also defined by the statute:

> For the purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information - -
>
> (1) has actual knowledge of the information;
>
> (2) acts in deliberate ignorance of the truth or falsity of the information; or
>
> (3) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent is required.

31 U.S.C. § 3729 (b) The provision allowing for a finding of liability without proof of specific intent to defraud was a feature of the 1986 amendments to the Act. As explained by one of the 1986 Act's sponsors:

> While the Act was not intended to apply to mere negligence, it is intended to apply in situations that could be considered gross negligence where the submitted claims to the government are prepared in such a sloppy or unsupervised fashion that [it] resulted in overcharges to the government.

United States v. Entin, 750 F. Supp. 512, 518 (S.D. Fla. 1990)(quoting 132 Cong. Rec. H9389 (daily ed. Oct 7, 1986) (Statement of Rep. Berman)). While the claims in this case were submitted to Pennsylvania Blue Shield as an insurance carrier, because the company is ultimately reimbursed by the Government, false Medicare and Medicaid claims submitted through Pennsylvania Blue Shield are held to violate the Act. See 31 U.S.C. § 3729(c) (defining claim to be any "request or demand" where the "United States Government provides any

portion of the money or property which is requested or demanded"); *See also Peterson v. Weinberger*, 508 F.2d 45,49 (5th Cir. 1975) *cert. denied* 423 U.S. 830 (1975) (false Medicare claims sent to Blue Cross/Blue Shield of Texas gave rise to liability under the False Claims Act); *United States ex rel. Fahner v. Alaska*, 591 F Supp. 794, 798-99 (N.D. 111. 1984) (submission of false Medicaid claims to Illinois Department of Public Aid gave rise to liability under False Claims Act).

The Court finds that, at times, Dr. Krizek was submitting claims for 90844 when he did not provide patient services for the requisite 45 minutes. The testimony makes clear that these submissions were made by Mrs. Krizek or Mrs. Anderson with little, if any, factual basis. Mrs. Krizek made no effort to establish how much time Dr. Krizek spent on a particular matter. Mrs. Krizek and Mrs. Anderson simply presumed that 45-50 minutes had been spent. There was no justification for making that assumption. In addition, Dr. Krizek failed utterly in supervising these agents in their submissions of claims on his behalf. As a result of his failure to supervise, Dr. Krizek received reimbursement for services which he did not provide.

These were not "mistakes" nor merely negligent conduct. Under the statutory definition of "knowing" conduct, the Court is compelled to conclude that the defendants acted with reckless disregard as to the truth or falsity of the submissions. As such, they will be deemed to have violated the False Claims Act.

CONCLUSION

Dr. Krizek must be held accountable for his billing system along with those who carried it out. Dr. Krizek was not justified in seeing patients and later not verifying the claims submitted for the services provided to these patients. Doctors must be held strictly accountable for requests filed for insurance reimbursement.

The Court believes that the Krizeks' billing practices must be corrected before they are permitted to further

participate in the Medicare or Medicaid programs. Therefore an injunction will issue, enjoining the defendants from participating in these systems until such time as they can show the Court that they can abide by the relevant rules.

The Court also will hold the defendants liable under the False Claims Act on those days where claims were submitted in excess of the equivalent of twelve (12) 90844 claims (nine patient-treatment hours) in a single day and where the defendants cannot establish that Dr. Krizek legitimately devoted the claimed amount of time to patient care on the day in question. The government also will be entitled to introduce proof that the defendants submitted incorrect bills when Dr. Krizek submitted bills for less than nine (9) hours in a single day. The assessment of the amount of overpayment and penalty will await these future proceedings.

OTHER OBSERVATIONS

While the Court does not discount the seriousness of the Krizeks' conduct here, this case demonstrates several flaws in this country's government health insurance program. The government was right in bringing this action, because it could not countenance the reckless nature of the reimbursement systems in this case. While we are in an age of computers, this does not mean that we can blindly allow coding systems to determine the amount of reimbursement without the physician being accountable for honestly and correctly submitting proper information, whether by code or otherwise.

Nonetheless, the Court found rather troubling some of the government's procedures that control reimbursements paid to providers of services. Here are some of these practices:

1) The government makes no distinction in reimbursement as to the status or professional attainment or education of the provider. Thus, a non-technical person rendering a coded service will be reimbursed the same amount as a board-certified physician.

2) The sums that the Medicare and Medicaid systems reimburse physicians for services rendered seem to be so far below the norm for charges reimbursed by non-governmental insurance carriers. Indeed, the amount could hardly support a medical practice. As the evidence shows in this case, Board certified physicians in most instances were paid at a rate less than $ 60 per hour and less than $ 35 per 1/2 hour. The government must certainly review these charges because if providers are not adequately compensated, they may not provide the level of care that our elderly and underprivileged citizens require. What is more, the best physicians will simply not come into the system or will refuse to take on senior citizens or the poor as patients.

3) The unrealistic billing concept of requiring doctors to bill only for face-to-face time is not consistent with effective use of a doctor's time or with the provision of good medical services. Doctors must be able to study, research, and discuss a patient's case and be reimbursed for such time.

4) When Medicare dictates that a physician must report each service rendered as a separate code item, the physician is entitled to believe that he will be reimbursed for each of the services rendered. In actuality, the system pays for only one of the multitude of services provided. If this were done by a private sector entity, it would be considered deceitful. Because the government engages in such a deceitful practice does not make it right.

These are the lessons learned by this Court during this case. Hopefully, HCFA will reexamine its reimbursement practices to see what, if any, changes should be made.

An appropriate order accompanies this opinion.

DATE: July 18, 1994

Stanley Sporkin
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 00-5385

September Term, 2000
93cv00054

United States of America,

Appellee

v.

George O. Krizek, M.D. and Blanka H. Krizek,

Appellants

The Washington Psychaitric Society, a District Branch of the American Psychiatric Association, Inc.,

Appellee

United States Court of Appeals
For District of Columbia Circuit
Filed
July 19, 2001
Clerk

BEFORE: Ginsburg, Chief Judge, Edwards, Williams, Sentelle, Henderson, Randolph, Rogers, Tatel and Garland, Circuit Judges

ORDER

Upon consideration of appellants' petition for rehearing en banc, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

By: /s/
Robert A. Bonner
Deputy Clerk

UNITED STATES COURT OF APPEALS

For the District Of Columbia Circuit

Civil Action No. 93-0054-JR

UNITED STATES OF AMERICA,

Plaintiff,

v.

GEORGE O. KRIZEK, M.D. and BLANKA H. KRIZEK.

Defendants.

Filed
Aug 29 2000
Nancy Mayer-Whittington, Clerk
U.S. District Court

JUDGMENT

Pursuant to the directive of the Court on August 29, 2000, it is, by the Court this 29th day of August, 2000.

ORDERED that Judgment is hereby entered for plaintiff, UNITED STATES OF AMERICA, against the defendants. GEORGE O. KRIZEK, M.D. and BLANKA II. KRIZEK. In the amount of Two Hundred Thirty-Seven Thousand One Hundred Five Dollars and Thirty-Nine Cents. ($237,105.39). plus costs. No prejudgment interest will be awarded to the plaintiff.

NANCY MAYER-WHITTINGTON, CLERK

By: /s/ _____

Deputy Clerk

FALSE CLAIMS ACT
31 U.S.C.

§3729. False claims

(a) LIABILITY FOR CERTAIN ACTS.- - Any person who - -

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

(4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

(5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defend the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or

property to be Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person, except that if the court finds that - -

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation; the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of the person. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) KNOWING AND KNOWINGLY DEFINED. For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(c) CLAIM DEFINED. - - For purposes of this section, "claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(d) EXEMPTION FROM DISCLOSURE. - - Any information furnished pursuant to subparagraphs (A) through (C) of subsection (a) shall be exempt from disclosure under section 552 of title 5.

(e) EXCLUSION. - - This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1954.

§3730. Civil actions for false claims

(a) RESPONSIBILITIES OF THE ATTORNEY GENERAL. The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) ACTIONS BY PRIVATE PERSONS.

(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60 day period or any extensions obtained under paragraph (3) the Government shall - -

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) RIGHTS OF THE PARTIES TO QUI TAM ACTIONS.

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as - -

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any

administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion is not subject to judicial review.

(d) AWARD TO QUI TAM PLAINTIFF. - -

(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceedings, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have

been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person

bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) CERTAIN ACTIONS BARRED.

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in section 201(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative proceeding in which the Government is already a party.

(4)(A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent

knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under this section which is based on the information.

(f) GOVERNMENT NOT LIABLE FOR CERTAIN EXPENSES. The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) FEES AND EXPENSES TO PREVAILING DEFENDANT. In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for the relief provided in this subsection.

§3731.False claims procedure

(a) A subpoena requiring the attendance of a witness at a trial or hearing conducted under section 3730 of this title may be served at any place in the United States.

(b) A civil action under section 3730 may not be brought--

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(c) In any action brought under section 3730, the United States shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(d) Notwithstanding any other provision of law, the Federal Rules of Criminal Procedure, or the Federal Rules of Evidence, a final judgment rendered in favor of the United States in any criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under subsection (a) or (b) of section 3730.

§3732. False claims jurisdiction

(a) Actions under section 3730.--Any action under section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States.

(b) Claims under state law.--The district courts shall have jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730.

42 U.S.C. § 1395

Section 1395. Prohibition against any Federal interference.

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control services are provided, or over the selection tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

42 C.F.R. § 405.301

CODE OF FEDERAL REGULATIONS
TITLE 42—PUBLIC HEALTH
CHAPTER IV—HEALTH CARE FINANCIING ADMINISTRATION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBPART C – SUSPENSION OF PAYMENT, RECOVERY OF OVERPAYMENTS, AND REPAYMENT OF SCHOLARSHIPS AND LOANS

GENERAL PROVISIONS

§ 405.301 Scope of subpart.

This subject sets forth the policies and procedures for handling of incorrect payments and recovery of overpayments.

[54 FR 41733, Oct. 11, 1989]

LIABILITY FOR PAYMENTS TO PROVIDERS OR SUPPLIERS AND HANDLING OF INCORRECT PAYMENTS

§ 405.350 Individual's liability for payments made to providers and other persons for items and services furnished the individual.

Any payments made under title XVIII of the Act to any provider of services or other person with respect to any item or service furnished an individual shall be regarded as a payment to the individual, and adjustment shall be made pursuant to §§ 405.352 through 405.358 where:

(a) More than the correct amount is paid to a provider of services or other person and the Secretary determines that:

(1) Within a reasonable period of time, the excess over the correct amount cannot be recouped from the provider of services or other person, or

(2) The provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

(b) A payment has been made under the provisions described in section 1814(e) of the Act, to a provider of services for items and services furnished the individual.

(c) For purposes of paragraph (a)(2) of this section, a provider or services or other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the determination of the carrier, the intermediary, or the Health Care Financing Administration that more than the correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid.

[41 FR 1402, Jan. 6, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 61 FR 49271, Sept 19, 1996]

§ 405.351 Incorrect payments for which the individual is not liable.

Where an incorrect payment has been made to a provider of services or other person, the individual is liable only to the extent that he has benefited from such payment.

42. C.F.R. § 424.32

CODE OF FEDERAL REGULATIONS
TITLE 42—PUBLIC HEALTH
CHAPTER IV—HEALTH CARE FINANCIING ADMINISTRATION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER B—MEDICARE PROGRAM
PART 424 – CONDITIONS FOR MEDICARE PAYMENT
SUBPART C – CLAIMS FOR PAYMENT

§ 424.32 Basic requirements for all claims.

(a) claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by HCFA in accordance with HCFa instructions.

2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate, or clinical social worker services must include appropriate diagnostic coding for those services using ICD-9-CM, and a claim for physician services furnished to an SNF resident under § 411.15(p)(2) of this chapter must also include the SNF's Medicare provider number.

(3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with § 424.36(b).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) A Part B claim filed by an SNF must include appropriate HCPCS coding.

(1) The prescribed forms for claims are the following:

HCFA-1450 -- Unform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

HCFA-1490S – Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

HCFA-1490U – Reuest for Medicare Payment by Organization. (For use by an organization request payment for medical service.)

HCFA-1491 – Request for Medicare Payment-Ambulance. (For use by an organization requesting payment for ambulance services.)

HCFA-1500 – Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

HCFA-1660 – Request for Information-Medicare Payment for Services to a Patient now deceased. (For use in requesting amounts payable under title XVIII to a decrease beneficiary.)

(c) Where claim forms are available. Excluding forms HCFA-1450 and HCFA-1500, all claims form prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, organizations. The HCFA-1450 and HCFA-1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from HCFA or any Social Security branch or district office, or from Medicare intermediaries or carriers. The HCFA-1490s is also available at local Social Security Offices.

[53 FR 12945, April 20, 1988; 59 FR 10299, March 4, 1994; 63 FR 20130, April 23, 1998; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998]

A-89

TESTIMONY
OF
GEORGE O. KRIZEK, M.D.
AND
BLANKA H. KRIZEK

SUBCOMMITTEE ON COMMERCIAL AND ADMINISTRATIVE LAW
COMMITTEE ON THE JUDICIARY
U.S. HOUSE OF REPRESENTATIVES

MAY 7, 1998

Mr. Chairman, Members of the Subcommittee. My husband and I are honored to be invited here today to testify about events that have profoundly changed our lives forever. We have been fighting to establish the truth about my husband's medical practice for almost six years now. It has been a very difficult thing to do in this era where arcane and Kafkaesque administrative rules can and do result in the criminalization of medicine, in times when HCFA (the Health Care Financing Administration) and Medicare tell the country daily how many billions of dollars are wasted in fraud, yet the "fraud" involved is often nothing more sinister than a failure to interpret complex and confusing regulations in the same way the government does, or is simply the result of an honest error. The public is encouraged to participate in fraud-hunting by calling a hotline number at HCFA, with the promise that if the doctor agrees to a monetary settlement, guilty or not, the informer may collect up to 30% of the resulting booty. Statistics show that the number of former patients, disgruntled employees, and even competing fellow physicians turned informers is growing daily. Most doctors accused of fraud are advised by the growing cadre of health-care industry lawyers to settle with the government immediately.

Any lawyer in this field will tell you that, if you choose to fight even the most bizarre accusation, based even on regulations that seem to you to admit of only one interpretation, you will be in courts for years, your legal bills will ruin you, your colleagues and friends will desert you, and stories about your purported fraud will appear in the media. The pressure will be enormous: your life will become nothing but the lawsuit, and your health might fail under such abuses. "You will be destitute, anyway," one of our first lawyers said when we refused to offer our home up to settle a lawsuit, which alleged that we perpetrated an $81 million Medicare and Medicaid fraud on the government. That suit was filed by the U.S. Government against my husband and me almost six years ago, pursuant to the False Claims Act. We were terrified and with good reason, for soon we entered into an unimaginable nightmare. We became convinced that we would lose our financial security and everything that we had worked so hard for in this country.

In 1863 Abraham Lincoln signed into law the False Claims Act in order to combat rampant fraud perpetrated on the Union Army during the Civil War and to punish cheating defense contractors. This law was amended in 1986; the requirement to prove intent to defraud was eliminated, and the burden of proof was effectively shifted from the Government to the Defendant, who therefore is now guilty until proven innocent. Damages were raised from a multiple of two to a multiple of three, and potential penalties for each claim filed increased from $2,000 to $10,000. I think that Abraham Lincoln would be very surprised to see that this law is being used today to terrorize hard-working doctors. Instead of penalizing doctors for the truly inexcusable offense of bilking the government and thus abusing the public trust, the net of this law has been cast much wider by federal administrators to ensnare doctors who fail to interpret regulations properly or to keep records in the precise fashion that the government prefers, even though the regulations are far from clear. We used to think that the growth of government in America was

benign because the American constitutional tradition could be expected to be a strong check on any abuses. We don't believe that anymore, and if President Lincoln were still alive today to see the monstrosity the government has become, with its hands in every pie, and more "law" than anyone could read in three lifetimes, law issued by unelected bureaucrats, he would agree with us.

HCFA obviously needed a good, "scandalous" medical billing case to start a series of prosecutions of doctors under the newly amended False Claims Act.

It remains a secret who selected my husband, an exceptional, dedicated doctor, a specialist in psychiatry, for this thankless role. Under the Freedom of Information Act (FOIA), an important, but in this case unhelpful, check on the discretion of federal administrators, we were informed that we would not be given access to 110 pages of documents responsive to our request, ostensibly since they revealed the identity of the informers involved in our case. We do know, however, from the documents that we did get, that my husband was targeted for investigation as an individual, by name, and not through a "random audit," as HCFA claims.

Here was a European doctor whose escape from Communist Czechoslovakia in 1966, with his family following in 1967, was dramatic enough for a movie. A man whose father, a jurist, was decorated for bravery in both world wars. A man willing to leave his comfortable life in Prague, Czechoslovakia when pressed to conduct politically-motivated forensic psychiatric examinations and to enter the Communist party. He chose for his family a very dangerous escape to freedom, because he believed, like his father before him, in the American brand of democracy. Never once in his life was his honesty or integrity, both in his professional and personal life, questioned.

After nearly forty years with my husband, I am qualified to confirm that.

While Dr. Krizek, known at the Washington Hospital Center, during his quarter of a century there, as one of the most hard-working and respected doctors, continued to work his routine seven-day weeks, the HCFA "special agents" were already hard at work trying to destroy his reputation and his medical practice. It was just before Christmas in 1989, when, under the pretext of a "Christmas delivery," three investigators appeared at our door. They said that they came from Medicaid and had some questions to ask about our billing practices. I am still asked why I let them in, since they had no official identification. The simple answer is that, although the visit was unusual, we had nothing to hide and I believed in the fairness of our adopted country's system.

For the next three hours, in a performance designed to scare us to death, one of the agents screamed and yelled while the other two laughed at me and made fun of my accent. The agents accused me of billing for non-existent patients, billing patients of other doctors, of "double-billing" both Medicare and Medicaid, and of "unjustly enriching" myself. For every patient named I could quickly find a file and proper documentation. But it became clear that these agents did not care and moreover were unfamiliar with billing procedures. What shocked me the most was when they told me that they had already rummaged through hundreds of Medicare and Medicaid patients files kept at the Washington Hospital Center. After this episode, our daughter, who is a lawyer, was assured that there was no evidence of wrongful billing found, and that the investigation was "routine." Dr. Krizek's contracts with Medicare and Medicaid specified that review of billing by these programs was permitted, so we accepted this version of events.

We never heard from the agents again until three years later, on Christmas Eve 1992, when a certified letter came from the U.S. Attorney's Office stating that we had falsely claimed "8,002" Medicare and Medicaid reimbursement claims, and that the Government was prepared to file a lawsuit against us. However, the letter said that the

Government would be willing to resolve this matter without filing suit "in exchange for an appropriate cash settlement." We made an appointment with the Assistant U.S. Attorney in charge of our case, in an attempt to find out what exactly we had done wrong. The response was simple: 'We are the Government, we don't have to show you anything -- you go home and find in your files what was wrong with your billing. Pay us hundreds of thousands of dollars and we won't file suit.' We felt that this was official extortion and resolved to fight.

The most outrageous aspect of the impending lawsuit was that my husband's Medicare and Medicaid contracts specified that the programs were obliged to notify a doctor if any problems with his billing were found and to educate him about proper billing methods. Obviously, the Government was now not honoring such contracts, and taking a "sue first, educate later" position. As our experiences indicate, the HCFA regulations and coding procedures are confusing enough that lawyers could spend weeks arguing over how to interpret them. Obviously, a medical practitioner who should, after all, spend most of his time helping his patients and ministering to them, should be treated differently than lawyers. Our experience in this case almost convinces us that the government is bent on turning everyone in the country into a lawyer, at least a part-time one, with the deluge of regulations that we are expected to comply with in order to function in modern society.

Only four days after our first meeting with the assistant U.S. Attorney, on January 11, 1993, at a hastily called press conference, then U.S. Attorney Jay Stevens told the media that as part of a "major health care fraud enforcement initiative," a lawsuit was being filed against local psychiatrist George O. Krizek and his wife Blanka for submitting "8,002 fraudulent multiple billings for patients' psychoanalytic sessions," with potential fines of $81 million. All day long, the local television and radio stations carried the story. Several patients and friends called to tell us that they had seen

the news report. In the complaint filed that same day, we were accused of "medically unnecessary" patient treatments, and of using the wrong billing codes to claim reimbursement for my husband's services. There was still no explanation of where the Government's numbers came from, or the specific patients to which the government was referring.

In the Spring of 1994, we endured a three-week trial during which the Government lost on almost every part of its complaint against us. Based on the testimony of Dr. Krizek and other witnesses, no "medically unnecessary treatment," "upcoding" or "miscoding" were found by the Court. The Court criticized directly HCFA for interpreting its codes in a way that was incomprehensible to the medical community. About 50 doctors, nurses and social workers provided oral or written testimony about Dr. Krizek's exceptional care of patients, many of whom were seriously mentally ill, poor, and/or homeless. One patient testified that Dr. Krizek had repeatedly saved his life.

The Government had not found one patient who would testify against my husband. We were also able to prove that the Government's one medical expert witness, Dr. Harvey Resnik, had barely read the patient charts that he was testifying about. The Government repeatedly tried to misuse its own statistics. The HCFA fraud coordinator testified that my husband's use of psychotherapy code 90844 was the "most aberrant of them all." When the Court ordered HCFA to produce its own printouts, it was revealed that two-thirds of other Washington-area psychiatrists used the code more often than my husband for the same kinds of treatments. While Dr. Krizek's income between 1986 and 1992 was about $100,000 a year and his total Medicare income for this period totalled about $250,000, the printouts revealed that some of his colleagues received up to five times more from the program. The HCFA investigators were found, in the Court's words, to be trying to "spin the Court" with its unfounded theories of the case, and the Court threatened to dismiss the lawsuit.

In fact, Washington Hospital Center records revealed that Dr. Krizek was one of the most cost-effective doctors for the Medicare and Medicaid programs, since he consistently had one of the shortest lengths of stay for admitted patients. When confronted with its misuse of its own statistics, HCFA represented that it would soon bring lawsuits against the other doctors listed on its printouts.

When the Court finally issued its opinion, however, the case took a bizarre twist for us. Although the Court ruled against the Government on all the elements of the original complaint, the Court found liability on the novel theory that my husband would be "presumed liable" under the False Claims Act for all medical services provided in excess of nine working hours on any one day. Can you imagine? Under such an absurd standard, all of the professionals in Washington, including many, if not all, members of this Committee and their staffs, would be guilty of a quasi-criminal act if they drew a portion of their paychecks from the Medicare and Medicaid program.

In fact, the records produced in our case had documented that Dr. Krizek had often worked very long days at the 800-bed hospital with which he was affiliated, especially on days when he was on call or covering for other doctors who were on vacation or otherwise absent. Based on this new theory of liability, the Court ordered us to pay $47,000 for services rendered in excess of nine hours in the six-year period, plus an additional penalty of $10,000 per patient, per treatment involved. The Washington Psychiatric Society attempted to intervene in the case to explain that hospital-based psychiatrists providing critical care sometimes had to work around theclock. But this was to no avail. It is our personal belief that the Court, while rejecting of necessity the lion's share of the government's claims felt obligated to throw the government a bone, especially after the government had invested so much in such a high-profile case.

Both we and the Government appealed the District Court's decision. We were outraged by the arbitrary amount

of the judgment, while the Government felt that the judgment was too low, and demanded a total of $5,750,000 in damages. The Association of American Physicians and Surgeons (AAPS) wrote an *amicus curiae* brief on our behalf at the Court of Appeals. The Government's sole reason for appealing seemed to be to squeeze as much money out of our case as possible. 'Don't worry, Doctor,' one participant declared, 'we'll leave you enough to live comfortably in the old country.' Another participant asserted that because the Government had invested so much money and so many resources in our case, they would "never" be willing to walk away empty-handed.

Meanwhile, the battle continues between the medical community and HCFA to try to clarify the use of the byzantine HCFA billing codes. Doctors, tired of continuously changing definitions and a lack of explanation, want HCFA to come up with a system that they can use without being accused of fraudulent billing. After years of paying social workers more money than board-certified doctors for submitting requests for reimbursement under the same psychotherapy code, 90844, HCFA finally appears to be recognizing that doctors render greater services in that they medically diagnose and evaluate patients. Last year, more importantly, HCFA finally began accepting 24 codes, rather than the original four, to reflect the great range of services provided by a psychiatrist. This year, implementation of further changes to the billing codes for psychiatrists were delayed, because both doctors and HCFA had to conclude that the new codes were still too confusing and too difficult for doctors to use. It is our deeply-held view that until these administrative problems are worked out, the government should concentrate its prosecutorial and enforcement resources on clear cases of fraud, instead of bringing cases like ours based on complicated theories and assumptions about how billing codes should have been, but are not, used by the medical community as a whole.

Our trial had a sad human aspect. For twenty years, until the fall of Communism, we had not been able to return to our homeland. Ironically, although travel was now possible, when my husband's 87-year-old mother was dying in Prague, my husband could not be with her in her last days because of the trial. She died knowing that her son was being sued in his new country by the Government.

One year after the trial, pending appeal, the Government placed a freeze on all of our assets, including our home. In January 1996, Dr. Krizek was diagnosed with cancer and operated on. When our daughter tried to meet with the Assistant U.S. attorney to tell him about her father's critical illness and to request a removal of the freeze, the Assistant U.S. Attorney had her escorted out of the building by armed security guards.

In its sixth year, our case is now on remand back before the District Court. We still live and breath this nightmare daily. Although we have won victories along the way, we are no match for the Government, with its endless resources and apparent willingness to stay in the ring until we are exhausted and defeated and give up the fight. Because of this case, my husband has had to close his practice and has lost his health. Although we have both been intensely patriotic in our new country, we must now step back and question whether what we have experienced at the hands of Government investigators and prosecutors meets any possible definition of democracy or due process.

Having had many of its legal theories foreclosed by the Court of Appeals, the government is now back in court attempting to prove that of the 1,825 days it originally claimed my husband billed falsely for, violations of the law occured on 5 of those days, three of which were spent working around the clock because my husband was covering for another doctor on vacation. We can only hope that the Court will see fit this time to reject the government's claim that my husband billed improperly for any of those 5 days, since this claim is based on making counterfactual

assumptions about how long particular treatments lasted. The treatments in question were often billed under codes that had no durations associated with them in the government's regulations. Thus, we find it hard to see how we can be found liable for submitting a false claim simply because the government wants to assume that these treatments lasted for a particular period of time. We can only hope these common-sense arguments prevail this time around.

My husband and I spent the first half of our lives first under the Nazi occupation and then under Communism in our native Czechoslovakia. Under Hitler and Stalin and even in Red China, the terror started by selecting average but ambitious young people who were taught how to hate others, how to use arms, and then to use these new and unchecked powers against their fellow citizens. That was how class struggle was fomented, through denouncing and informing on your neighbors, by instilling fear. Today, the armies of new "special agents" of the regulatory bureaucracy, driven by a bounty system, are apparently being trained in a seemingly less, but we think, even more dangerous way. The new way is insidious, more deliberate, cleverer, but the tyranny and the loss of liberty can often be as great.

The country should wake up. The uncontrolled use of the False Claims Act might be only the beginning, the first wave in an attempt to turn the misinterpretation of confusing regulations into massive civil liability, or even crimes. Democracy can be destroyed quickly if the system of checks and balances stops functioning.

My husband and I have been fighting for years, and we are exhausted. It is up to you, our lawmakers, to fight not only for us but also for other doctors unjustly prosecuted under this perverse law or otherwise subjected to abuses of administrative authority throughout the country. We can only put our trust in your integrity. Thank you.